HEALTH REQUIREMENTS

Child's Name | Date of Birth

IMMUNIZATIONS	Date 1st Dose	Date 2nd Dose	Date 3rd Dose	Date 1st Booster	Date 2nd Booster
DPT/TD					
Polio					
Hib-CV					
Hep A					
Hep B					
PCV					
MMR Vaccine		Physician's Verifications Must Be Submitted			
Varicella		Measles- Date of Illness		Mumps- Date of Illness:	

NOTE: You may submit a copy of an immunization record signed or stamped by a physician or health professional

Vision & Hearing Test: To be completed at the child's four year old check-up per Texas Department of Health.

Results: **Vision:** ____/____ ☐ Pass ☐ Fail Corrective Lenses ☐ Yes ☐ No

Hearing: Right Ear: ☐ Pass ☐ Fail Left Ear: ☐ Pass ☐ Fail

Referred to a specialist? Vision: ☐ Yes ☐ No Hearing: ☐ Yes ☐ No

_____ Signature (or stamp)-Physician or Health Professional

_____ Date

_____ Signature- Staff Making Handwritten Copy of Record

_____ Date

ADMISSION REQUIREMENT: One of the following must be presented when your pre-school age child is admitted to the day care facility or within one week of admission. Check to indicate the option you select:

☐ Doctor's Statement: I have examined the above-named child within the past year and find that he/she is physically able to take part in the day care program. _____ Physician's Signature _____ Date

☐ A form or written statement from health service or clinic.

If you do not have any of the above:

☐ My child has an appointment for a physical examination:

Date | Name and Address of Physician OR Address of EPSDT Screening Site

I will submit physician's statement, EPSDT form, or health service or clinic form to the day care facility following examination

_____ Signature-Parent or Legal Guardian

_____ Date