

# HEALTH REQUIREMENTS

Name of Child:				Date of Birth:	
IMMUNIZATIONS	Date / dose 1	Date / dose 2	Date / dose 3	Date / booster	Date / booster
DTP / DTaP / DT					
POLIO IPV or OPV					
MEASLES Rubeola / Serampion					
MUMPS					
RUBELLA					
Hib					
Hepatitis A					
Hepatitis B					
TB TEST (if required)	<input type="checkbox"/> Positive	<input type="checkbox"/> Negative	Date:		
Varicella (see below)					

Varicella (chickenpox) vaccine is not required if your child has had chickenpox disease. If your child has had chickenpox, please complete the statement: My child had varicella disease (chickenpox) on or about (date) \_\_\_\_\_ and does not need varicella vaccine.

\_\_\_\_\_ Date \_\_\_\_\_

Parent's signature

Signature of Health Care Professional \_\_\_\_\_ Date \_\_\_\_\_

Signature of staff making handwritten copy of record \_\_\_\_\_ Date \_\_\_\_\_

**ADMISSION REQUIREMENT:** One of the following must be presented when your child (under the age of 5 years) is admitted to the day care facility or within one week of admission. Check to indicate the option you select:

HEALTH-CARE PROFESSIONAL'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.

\_\_\_\_\_ Date \_\_\_\_\_

Health Care Professional's Signature

A copy of the medical screening form of the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program, if no referral for further diagnosis and treatment is indicated.

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

**If you do not have any of the above:**

PARENT'S STATEMENT: My child has been examined within the past year by a health care professional and is able to participate in the day care program:

Name and address of health care professional:

Within 12 months of admission, I will obtain a health care professional's statement and will submit it to the day care facility.  
OR

My child has an appointment for a physical examination:

Date: \_\_\_\_\_ Name and Address of health care professional: \_\_\_\_\_

I will submit the statement, from a health care professional to the child-care facility following the examination.

\_\_\_\_\_ Date \_\_\_\_\_

Signature - Parent or Legal Guardian

HEARING	DATE	SIGNATURE			
Hz	1000	2000	4000	PASS	<input type="checkbox"/>
R				FAIL	<input type="checkbox"/>
L					
VISION	DATE	SIGNATURE			
R20/	L20/			PASS	<input type="checkbox"/>
				FAIL	<input type="checkbox"/>

NOTE: If medical diagnosis and treatment and / or immunization and TB testing conflict with your religious beliefs, you must sign an affidavit to that effect and attach it to this form. If immunization and / or TB testing would be injurious to your child or family, you must obtain a certificate (signed by a health care professional) to that effect and attach it to this form.