

ADMISSION INFORMATION

HEALTH FORM					
Name of Child:				Date of Birth:	
IMMUNIZATIONS	Date / dose 1	Date / dose 2	Date / dose 3	Date / dose 4	Date / booster
Hepatitis B					
DTP / DTaP / DT					
Hib					
Polio (IPV or OPV)					
Measles, Mumps. Rubella					
Rubella					
Varicella (see below)					
Pneumococcal Conjugate Vaccine					
Hepatitis A					
Rotavirus					
Meningococcal					
TB Test (if required)	<input type="checkbox"/> Positive	<input type="checkbox"/> Negative	Date: _____		
Signature or stamp of a physician or public health personnel verifying immunization information above. <div style="display: flex; justify-content: space-between; margin-top: 10px;"> _____ _____ </div> <div style="display: flex; justify-content: space-between; margin-top: 5px;"> Signature Date </div>					
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. <div style="display: flex; justify-content: space-between; margin-top: 10px;"> _____ _____ </div> <div style="display: flex; justify-content: space-between; margin-top: 5px;"> Parent's signature Date </div>					
<input type="checkbox"/> I am excluding my child from the immunization requirements for reasons of conscience, including a religious belief. I have attached an official notarized affidavit form developed and issued by the Department of State Health Services. I understand this affidavit is valid for 2 years.					
For additional information regarding immunizations contact the Department of State Health Services at http://www.dshs.state.tx.us/immunize/school_info.htm					

ADMISSION REQUIREMENT: If your child does not attend pre-kindergarten or school away from the child-care operation, one of the following 3 options must be presented **before your child is admitted to the ELC.**

Please check only one option:

- 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.

Health Care Professional's Signature
Date
- A signed and dated copy of a **health care professional's statement** is attached. Immunization record alone is not sufficient.
- Medical diagnosis and treatment conflict with the tenets and practices of a recognized religious organization, which I adhere to or am a member of; I have attached a signed and dated affidavit stating this.

Vision and Hearing Screening for all children four years and older.

VISION	R 20/ _____	L 20/ _____	<input type="checkbox"/> PASS <input type="checkbox"/> FAIL	
SIGNATURE _____		DATE _____		
HEARING	1000 Hz	2000 Hz	4000 Hz	<input type="checkbox"/> PASS <input type="checkbox"/> FAIL
R				
L				
SIGNATURE OF SCREENER _____		DATE _____		

Name and address of health care professional:

Signature - Parent or Legal Guardian
Date