

Child's Name: _____ Child's Date of Birth: _____

Physician Statement

This form must be completed, signed, and dated by your child's physician.

<u>Age</u>	<u>Vaccine</u>	<u>Date</u>		<u>Date</u>
2 months	#1 DPT/DTaP	_____	Chicken Pox	_____
4 months	#2 DPT/DTaP	_____	Measles	_____
6 months	#3 DPT/DTaP	_____	Mumps	_____
15-18 months	#4 DPT/DTaP	_____		
After 4th birthday	#5 DPT/DTaP	_____	Tuberculin Skin Test or X-ray Results Negative/Positive	_____

2 months	#1 Polio	_____		
4 months	#2 Polio	_____		
6 months	#3 Polio	_____		
12-18 months	#4 Polio	_____		
After 4th birthday	#5 Polio	_____		

Hearing and Vision

Hearing	Pass ()	Rescreen ()	_____
Vision	Pass ()	Rescreen ()	_____

These tests are required annually for children 4 years and older.

Special Problems

6-18 months	Hep A	_____	Please list any allergies and/or special conditions/needs: _____	
Birth	#1 Hep B	_____	_____	
2 months	#2 Hep B	_____	_____	
6-18 months	#3 Hep B	_____	_____	

After 1st birthday	#1 MMR	_____	Height	_____	Weight	_____
After 2nd birthday	#2 MMR	_____				

12-18 months	Varicella/Chicken Pox	_____	By the time your child is 4 years old, all blanks for dates of immunizations should be filled in and complete.		
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I hereby certify that _____
(Child's Full Name)

Has been examined by me on _____, and is physically and mentally capable of participating in the activities at School for Little Children.

Doctor's examination visit must have been completed in the last six months before the child registers at the school.

Physician's Name or Stamp (please print): _____

Address _____ City _____
State _____ Zip Code _____ Phone _____

Physician's Signature: _____

Copy of Medical Insurance card received