

# 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.					
				Signature	Date
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.					
				Parent's signature	Date
<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 <a href="http://www.dshs.state.tx.us/immunize/school_info.htm">http://www.dshs.state.tx.us/immunize/school_info.htm</a>					

**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
R			
L			
			<input type="checkbox"/> PASS <input type="checkbox"/> FAIL
SIGNATURE OF SCREENER _____		DATE _____	

Name and address of health care professional:

\_\_\_\_\_

\_\_\_\_\_ **Signature - Parent or Legal Guardian** \_\_\_\_\_ **Date**