

Child's Name _____ Date of Birth _____

MEDICAL STATEMENT

Immunizations	Date/Dose 1	Date/Dose 2	Date/Dose 3	Date/Dose 4
Polio (IPV or OPV)	_____	_____	_____	
DTaP/DT/DTP	_____	_____	_____	_____
Hib	_____	_____	_____	
Hepatitis B	_____	_____	_____	
MMR	_____			
Varicella	_____	or Chicken Pox case	_____	
Hepatitis A	_____	_____		
Pneumococcal Conjugate Vaccine	_____	_____	_____	_____
<i>For 4 year-olds only</i>				
Vision Test	R 20/_____	L 20/_____	_____ Pass	_____ Fail
Hearing Test	1000Hz	2000Hz	4000Hz	
Right	_____	_____	_____	_____ Pass _____ Fail
Left	_____	_____	_____	

Known allergies _____

Existing illness _____

Previous injury/serious illness/hospitalization during the past 12 months _____

Special needs _____

I have examined _____ within the last 12 months and have determined that
(Child's name)
he/she is physically able to participate in a preschool program.

Physician's signature _____ Date _____

Physician's name (Please print or type) _____

Address _____ Phone _____

I authorize the health provider named above to share this information with Beehive Parent Child Center, Inc.

Parent's signature