

PEDIATRIC HEALTH STATEMENT

Child's Name:	Date:
☐ This above-named child has been examined and is in suitable condition for participation in group care. ☐ This above-named child has been immunized in accordance with Texas requirements. ☐ This above-named child has not been immunized in accordance with Texas requirements.	
Doctors Office:	Telephone:
Name of Physician/PA/CNP:	Date of exam:
Signature of Physician/PA/CNP:	
Street Address	City
State	Zip
** Please attach a copy of the shot records to this form **	
☐ I have declined to have my child immunized against one or more diseases. ** Please attach a signed, notarized affidavit.**	
Parent Signature:	Date: