Tarrytown Children's Center # (512) 477-5851
2614 Exposition Blvd, Austin TX 78703

HEALTH REQUIREMENTS

Child's name___________________________________ **Birth date**_________________

*To be in compliance with the state, the following must be **annually** updated:*

I. A doctor's statement of child's well-check:

"I have examined _____________________________________ within the past 12 months and find that he/she is physically able to take part in the program at Tarrytown Children's Center."

Date of well check________________________

Physician's signature_______________________________________

Date________________________

II. Up to date immunizations: (Signed photocopy of health record acceptable- please attach.)

IMMUNIZATIONS	Date/dose 1	Date/dose 2	Date/dose 3	Date/dose 4	Date/dose 5
HEP B					
DT aP					
HIB					
POLIO					
MMR					
VARICELLA					
VARICELLA HISTORY	DATE OF DISEASE				
HEP A					
PNEUMOCOCCAL CONJUGATE					
PNEUMOCOCCAL POLYSACCHARIDE					
TETRAMUNE/ DTP + HIB					
TB Test	DATE READ	RESULTS <> Negative	RESULTS <> Positive		

___________________________________ Signature – Physician or Health Personnel

__________ Date

____ Signature – Staff making handwritten copy of records

Note: If medical diagnosis & treatment and/or immunizations & TB testing conflict with your religious beliefs, you must sign an affidavit to that effect and attach it to this form. If immunizations and/or TB testing would be injurious to your child or family, you must obtain a certificate (signed by the physician) to that effect and attach it to this form. For additional information regarding immunizations, visit the Texas Department of State Health Services website at www.dshs.state.tx.us/immunize/publichealth.shtm.