3015 North Macgregor Way
Houston, Texas 77004
Phone : (832) 217 - 3300
Fax : (832) 217 - 3303

Health Statement

Name of Child _____ Date of Birth _____

I have examined the above child within the past year and find that he/she is able to take part in the preschool program.
Health Care Professional Name _____
Address _____ City _____ State _____ Zip _____
Signature _____ Date _____

Age Vaccine	Birth	1 mos	2 mos	4 mos	6 mos	12 mos	15 mos	18 mos	19-23 mo	2-3 yrs	4-6 yrs
Hepatitis B											
Rotavirus											
Diphtheria, Tetanus, Pertussis											
Haemophilus Influenzae type B											
Pneumococccal											
Inactivated Poliovirus											
Influenza											
Measles, Mumps, Rubella											
Varicella											
Hepatitis A											
Meningocccal											

TB Test (if required) *please circle* Positive Negative Date _____

Signature or Stamp of physician or public health personnel verifying immunization information above.

Physician Signature _____ Date _____

Varicella (chickenpox) vaccine is not required if your child has had chickenpox disease. If you child has had chickenpox, please complete the statement: My child had varicella (chickenpox) on or about (date) _____
and does not need varicella vaccine.

Complete ONLY if Applicable

____ 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.

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.

Parent/Guardian Signature: _____ Date: _____