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	_____	_____	_____	_____	
For 4 year-olds only 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