Physician's 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:_____

Health Care Professional Signature:_____ Date: _____

Vaccine	Date/Dose 1	Date/Dose 2	Date/Dose 3	Date/Dose 4	Date/Booster
Hepatitis B					
Rotavirus					
Diphtheria, tetanus, Pertussis					
Haemophilus Influenzae Type B					
Pneumococcal					
Inactivated Poliovirus					
Influenza					
Measles, Mumps, Rubella					
Varicella (see below)					
Hepatitis A					
Meningococcal					

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

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

Signature: _____Date: _____

-OR-

I have provided the childcare operation with a copy of my child's most current immunization record.

Parent Signature: _____ Date: _____

Complete ONLY if Applicable

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

Parent Signature: _____ *Date:* _____

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 Signature: _____ *Date:* _____

For additional information regarding immunizations contact the Department of State Health Services at www.dshs.state.tx.us/immunize/public.shtm

Parent Signature: _____ Date: _____