

HEALTH REQUIREMENTS

Name of Child:						Date of Birth:					
Age ▶ Vaccine ▼	Birth	1 mo	2 mos	4 mos	6 mos	12 mos	15 mos	18 mos	19-23 mos	2-3 yrs	4-6 yrs
Hepatitis B											
Rotavirus											
Diphtheria, Tetanus, Pertussis											
Haemophilus Influenzae Type B											
Pneumococcal											
Inactivated Polio Virus											
Influenza											
Measles, Mumps, Rubella											
Varicella											
Hepatitis A											
Meningococcal											
Signature or stamp of physician or public health personnel verifying immunization information above: _____											
Health Care Professional's Signature						Date					
Name and address of health care professional:											
_____ Signature of Parent or Legal Guardian						_____ Date					
Varicella (chickenpox) vaccine is not required if your child has had chickenpox disease. If your child has had chickenpox, please complete the following statement: My child had Varicella disease (chickenpox) on or about (date) _____ and does not need Varicella vaccine.											
_____ Signature of Parent or Legal Guardian						_____ Date					
<input type="checkbox"/> 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.											
For additional information regarding immunizations contact the Department of State Health Services at http://www.dshs.state.tx.us/immunize/schoolinfo.htm											

ADMISSION REQUIREMENT: One of the following must be presented **upon admission** to the school **or within one week of admission**:

Please check **one** option:

1. HEALTH CARE PROFESSIONAL'S STATEMENT: I have examined the above named child within the past year and find that he/she is physically able to take part in the school program.

Health Care Professional's Signature

Date

2. A signed and dated copy of a health care professional's statement is attached.

3. Medical diagnosis and treatment conflict with the tenets and practices of a recognized religious organization of which I am an adherent or a member. I have attached a **signed and dated affidavit** stating this.

4. My child has been examined within the past year by a health care professional and is able to participate in the school program. Within 12 months of admission, I will obtain a health care professional's signed statement and will submit it to the school.

VISION	R 20/ _____	L 20/ _____	<input type="checkbox"/> PASS <input type="checkbox"/> FAIL
HEARING	1000 HZ	2000 HZ	<input type="checkbox"/> PASS <input type="checkbox"/> FAIL
R			
L			

Signature of Health Care Professional Providing Vision and Hearing Screening

Date

Signature of Parent or Legal Guardian

Date