

# IMMUNIZATION HEALTH REQUIREMENTS

Center \_\_\_\_\_

Fax to: (817)788-1885

Name of child	Date of birth:				
Immunizations	Date / Dose#1	Date/ Dose #2	Date/ Dose #3	Date / Dose #4	Date/ Booster
DPT / DTaP					
POLIO					
MMR					
H.I.B.					
HEP.B.					
VARICELLA					
OTHER:					
OTHER:					
OTHER:					
OTHER:					

**History of Diseases:**

Disease:	Date:	Disease:	Date:
Chickenpox	_____	Poliomyelitis	_____
Diphtheria	_____	Scarlet Fever	_____
German Measles	_____	Tuberculosis	_____
Measles	_____	Whooping Cough	_____
Mumps	_____	Other (Specify)	_____

\_\_\_\_\_  
Signature – Physician / Health Personnel \_\_\_\_\_  
Date

**Admission Requirement:** One of the following must be presented when your pre-school child is admitted to the day care facility or within one week of admission:

**Doctor'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 day care program.

\_\_\_\_\_  
Physician's Signature \_\_\_\_\_  
Date

**OR**

**\*\*Parent's Statement:** My child has been examined by this physician within the past year and find that he / she is physically able to take part in the day care program:

Physician's Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Phone: ( ) \_\_\_\_\_

\_\_\_\_\_  
Parent or Legal Guardian Signature \_\_\_\_\_  
Date

**\*\* A Parent's statement must be followed within 12 months with a physician's statement.**