



COVENANT PRESBYTERIAN PRESCHOOL & CDO

MEDICAL FORM 2017-2018

(Due back to the Preschool by August 1st. Completed form may be faxed to 512-334-3091.)

Child's Name \_\_\_\_\_ Birth Date \_\_\_/\_\_\_/\_\_\_

Age on Sept. 1, 2017 \_\_\_\_\_

IMMUNIZATIONS (Please list month, day, year!!)

NOTE: If you are delaying or opting out of vaccinations, even under doctor recommendations, you must submit a notarized affidavit from the Texas Department of State Health Services. Your doctor must still complete the bottom portion of this form to be turned in with the affidavit.

http://www.dshs.state.tx.us/immunize/docs/faq\_exemption.pdf

Diphtheria/Tetanus/Pertussis (DTaP) (List all dates, not just booster dates.)

- 1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_ 4. \_\_\_\_\_ (all 4 doses must be completed by 15 months)
5. \_\_\_\_\_ (Past fourth birthday booster)

POLIO (OPV or IPV)

- 1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_ Booster \_\_\_\_\_ (One booster past 4th birthday)

MMR (Measles, Mumps, Rubella)

- 1. \_\_\_\_\_ (On or after 1st birthday; before 15 months)
2. \_\_\_\_\_ (Must be given at least 30 days after 1st MMR or by age 5)

HibCV or Hib PV 1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_ 4. \_\_\_\_\_
(PPrimary Series or one shot past 15 months)

VARICELLA (Chicken Pox) \_\_\_\_\_

HEPATITIS A \_\_\_\_\_

HEPATITIS B \_\_\_\_\_

PNEUMOCOCCAL (PCV) \_\_\_\_\_

OTHER \_\_\_\_\_

CHRONIC CONDITIONS \_\_\_\_\_

ALLERGIES, SPECIAL DIET, RESTRICTIONS OF PHYSICAL ACTIVITY, SPECIFIC MEDICATION, ETC. \_\_\_\_\_

NONE

\*\*Mandatory for 4-and 5-year-olds\*\*

Table with columns for HEARING, Date, Signature, and frequency (Hz: 250, 500, 1000, 2000, 4000, 6000). Rows for Right/Left at 25 dB and Pass/Fail status.

VISION Date \_\_\_\_\_ Signature \_\_\_\_\_
Right: 20/\_\_\_\_\_ Left: 20/\_\_\_\_\_ Pass: \_\_\_\_\_ Fail: \_\_\_\_\_

Is this child able physically and mentally to participate in group activities? \_\_\_\_\_
I have examined \_\_\_\_\_ within the past 12 months and find her/him free of infection and communicable diseases and able to participate in all programs offered in the Covenant Presbyterian Preschool at the Covenant Presbyterian Church.

Signature of Doctor \_\_\_\_\_ Date \_\_\_\_\_

Phone # \_\_\_\_\_ Address \_\_\_\_\_

TO BE FILLED OUT BY YOUR DOCTOR

