



covenant

PRESBYTERIAN PRESCHOOL

MEDICAL FORM 2023-2024

Name of Child: _____ Date of Birth ____/____/____

IMMUNIZATIONS (Include month, day, year) Completed form may be faxed to 512-334-3091.

NOTE: If you are delaying or opting out of any vaccinations, even under doctor recommendations, you must submit a notarized affidavit from the Texas Dept. 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. _____ (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. _____
(Primary Series or one shot past 15 months)

VARICELLA (Chicken Pox) _____

HEPATITIS A _____

HEPATITIS B _____

PNEUMOCOCCAL (PCV) _____

OTHER _____

CHRONIC CONDITIONS _____

ALLERGIES, SPECIAL DIET, PHYSICAL ACTIVITY RESTRICTIONS, SPECIFIC MEDICATION, ETC. _____

NONE

This portion is mandatory for 4-and 5-year-olds.

HEARING	Date _____	Signature _____				
Hz	250	500	1000	2000	4000	6000
Right	_____	_____	_____	_____	_____	_____
Left	_____	_____	_____	_____	_____	_____
25 dB	1000	2000	4000			
Right	_____	_____	_____	Pass _____		
Left	_____	_____	_____	Fail _____		

VISION Date _____ Signature _____
Right: 20/____ Left: 20/____ Pass: _____ Fail: _____

Form will not be accepted without this section completed by your doctor.

Is this child able physically and mentally to participate in group activities? _____

I have examined _____ within the past 12 months and find him/her 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** _____

Office Address & Phone: _____

TO BE COMPLETED BY YOUR DOCTOR