The Yellow School at Memorial Drive Presbyterian Church

MEDICAL INFORMATION

Child's Name:				Birth Date:	
IMMUNIZATIONS	Dose 1 Date	Dose 2 Date	Dose 3 Date	Booster Date	Booster Date
DTP/DtaP/DT					
Polio (IPV or OPV)					
Measles (rubeola)					
Mumps					
Rubella					
Hib					
Hepatitis A					
Hepatitis B					
TB Test	◯ Positive ◯ Negative Date:				
Varicella					
Rotavirus					
Meningococcal					
PCV 7 Prevenar					

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 a school program.

_____ _____

Physician's Signature **Date**

MEDICAL HISTORY (may be completed by parents):

Previous hospitalization? ◯ Yes ◯ No If yes, why?

Operations? ◯ Yes ◯ No
If yes, please describe:

Allergies? ◯ Yes ◯ No
If yes, what are they, and what are the reactions?

Physical handicaps? ◯ Yes ◯ No
If yes, please describe:

History of convulsions? ◯ Yes ◯ No

History of heart trouble? ◯ Yes ◯ No

Congenital problems? ◯ Yes ◯ No

Previous diseases or illnesses? ◯ Yes ◯ No If yes, what?

Need for daily and/or long term medication? ◯ Yes ◯ No
If yes, please describe:

PARENT'S SIGNATURE _____

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: www.dshs.state.tx.us/immunize/school_info.htm