

# HEALTH REQUIREMENTS

Form 2935  
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Name of Child:				Date of Birth:	
<b>IMMUNIZATIONS</b>	Date (dose 1)	Date (dose 2)	Date (dose 3)	Date / booster	Date / booster
<b>DTP / DtaP /DT</b>					
<b>POLIO – IVP or OPV</b>					
<b>MEASLES</b> Rubeolla / Sarampion					
<b>MUMPS</b>					
<b>RUBELLA</b>					
Hib					
Hepatitis A					
Hepatitis B					
<b>TB TEST</b> (if required)	<input type="checkbox"/> Positive	<input type="checkbox"/> Negative	Date:		
Varicella (see below)					
<p>Varicella (chickenpox) vaccine is not required if your child has had chickenpox disease. If your child has had chickenpox, please complete the statement: My child had varicella disease (chickenpox) on or about (date) _____ and does not need varicella vaccine.</p> <p>Parent's signature _____ Date: _____</p> <p>Signature of Health Care Professional _____ Date _____</p> <p>For additional information regarding immunizations contact the Department of State Health Services at <a href="http://www.dshs.tx.us/immunize/school_info.htm">http://www.dshs.tx.us/immunize/school_info.htm</a></p>					

<p><b>ADMISSION REQUIREMENT:</b> If you child does not attend pre-kindergarten or school away from the hild-care operation, one of the following must be presented when your child is admitted to the child-care operation or within one week of admission.</p> <p><input type="checkbox"/> <b>HEALTH CARE PROFESSIONAL STATEMENT:</b> 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.</p> <p>Health Care Professional Signature _____ Date _____</p> <p><input type="checkbox"/> A signed and dated copy of a health care professional's statement is attached.</p> <p><input type="checkbox"/> <b>PARENT'S STATEMENT:</b> My child has been examined within the past year by a health care professional and is able to participate in the day care program. Within 12 months of admission, I will obtain a health care professional's signed statement and will submit it to the child-care operation.</p> <p>Name and address of health care professional:</p> <p>Signature - Parent or Legal Guardian _____ Date: _____</p> <p><input type="checkbox"/> Medical diagnosis and treatment conflict with the tenets and practices of a recognized religious organization, which I adhere to or am a member of; I have attached a signed and dated affidavit stating this.</p>	
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<b>VISION</b>	R20/ _____	L20/ _____	<input type="checkbox"/> PASS <input type="checkbox"/> FAIL
Signature _____			Date: _____

<b>HEARING</b>	1000 Hz	2000 Hz	4000 HZ	<input type="checkbox"/> PASS <input type="checkbox"/> FAIL
<b>R</b>				
<b>L</b>				
Signature _____				Date: _____

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