

First Place Preschool

Phone# 469-568-1250 Fax# 972-492-6236

HEALTH CARE REQUIREMENTS

Name of Child: _____	Date of Birth: _____
----------------------	----------------------

Immunizations

Immunizations	Date/ Dose 1	Date/ Dose 2	Date/ Dose 3	Date/ Booster
DTP/ DTaP/ DT				
Polio IPV or OPV				
Measles Rubeola/Serampion				
Mumps				
Rubella				
Hib				
Hepatitis A				
Hepatitis B				
TB Test (if required)				
Pneumococcal PCV7				
**Varicella (see below)				

This form must be completed and received by the office BEFORE the child can attend class.

PHYSICIAN 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 preschool program.

Physician/Health Care Professional Signature: _____ Date: _____

Hearing and Vision Screening (For 4 year olds ONLY)

HEARING	1000 Hz		2000 Hz		4000 Hz		
Right							_____ Pass
Left							_____ Fail
VISION	R20/ _____		L20/ _____		_____ Pass _____ Fail		

Clinician Signature: _____ Date: _____

****Please Note:** 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.

Parent's Signature: _____ Date: _____