



# Austin Peace Academy HEALTH REQUIREMENTS

Name of Child:				Date of Birth :	
IMMUNIZATIONS	Date / dose 1	Date / dose 2	Date / dose 3	Date / booster	Date / booster
DTP / DTaP / DT					
POLIO IPV or OPV					
MEASLES Rubeola/Serampion					
MUMPS					
RUBELLA					
Hib					
Hepatitis A					
Hepatitis B					
TB TEST (if required)	<input type="checkbox"/> Positive	<input type="checkbox"/> Negative	Date :		
Varicella (see below)					
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	

Signature - Physician or Health Personnel

Date

Signature - Staff Making Handwritten Copy of Record

Date

<b>ADMISSION REQUIREMENT:</b> One of the following must be presented when your child (under the age of 5 years) is admitted to the day care facility or within one week of admission. Check to indicate the option you select:	
<input type="checkbox"/> 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 the day care program.	_____ Physician's Signature
_____ Date	
<input type="checkbox"/> A copy of the medical screening form of the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program, if no referral for further diagnosis and treatment is indicated.	
<input type="checkbox"/> A form or written statement from a health service or clinic.	
<b>If you do not have any of the above:</b>	
<input type="checkbox"/> PARENT'S STATEMENT: My child has been examined within the past year by a licensed physician and is able to participate in the day care program: Name and address of Physician <b>OR</b> address of EPSDT Screening Site:	
<input type="checkbox"/> Within the next 12 months, I will obtain a physician's statement, a copy of the medical screening form from the EPSDT Program, or a form or statement from a health service or clinic and will submit it to the day care facility.	
<b>OR</b>	
<input type="checkbox"/> My child has an appointment for a physical examination: Date: _____ Name and Address of Physician <b>OR</b> Address of EPSDT Screening Site: _____	
I will submit the physician's statement, EPSDT form, or health service or clinic form to the day care facility following the examination.	
_____ Signature - Parent or Legal Guardian	
_____ Date	

HEARING	DATE			SIGNATURE	
Hz	1000	2000	4000	PASS <input type="checkbox"/>	
R				FAIL <input type="checkbox"/>	
L				FAIL <input type="checkbox"/>	
VISION	DATE			SIGNATURE	
R20/	L20/			PASS <input type="checkbox"/>	FAIL <input type="checkbox"/>

*NOTE: If medical diagnosis and treatment and / or immunization and TB testing conflict with your religious beliefs, you must sign an affidavit to that effect and attach it to this form. If immunization and / or TB testing would be injurious to your child or family, you must obtain a certificate (signed by a physician) to that effect and attach it to this form.*