

Child's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

### MEDICAL STATEMENT

Immunizations	Date/Dose 1	Date/Dose 2	Date/Dose 3	Date/Dose 4	Date/Dose 5
Polio (IPV or OPV)	_____	_____	_____	_____	_____
DTaP/DT/DTP	_____	_____	_____	_____	_____
Hib	_____	_____	_____	_____	_____
Hepatitis B	_____	_____	_____	_____	_____
MMR	_____	_____	_____	_____	_____
Varicella	_____	_____	_____	_____	_____
			or Chicken Pox case	_____	_____
Hepatitis A	_____	_____	_____	_____	_____
Pneumococcal Conjugate Vaccine	_____	_____	_____	_____	_____
<i>For 4 year-olds only</i>					
Vision Test	R 20/_____	L 20/_____	_____	Pass	Fail
Hearing Test	1000Hz	2000Hz	4000Hz	_____	_____
Right	_____	_____	_____	Pass	Fail
Left	_____	_____	_____	_____	_____

Known allergies \_\_\_\_\_

Existing illness \_\_\_\_\_

Previous injury/serious illness/hospitalization during the past 12 months \_\_\_\_\_

Special needs \_\_\_\_\_

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I have examined \_\_\_\_\_ within the last 12 months and have  
(Child's name)  
determined that he/she is physically able to participate in a preschool program.

Physician's signature \_\_\_\_\_ Date \_\_\_\_\_

Physician's name (Please print or type) \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_