



1320 West Brazos Avenue
 West Columbia, TX 77486
 P: 979.345.3333
 F: 979.345.7896

Physician's Statement

Name of Child _____ Date of Birth _____

I have examined the above child within the past year and find that he/she is able to take part in the preschool program.
 Health Care Professional Name _____
 Address _____ City _____ State _____ Zip _____
 Signature _____ Date _____

Age	Birth	1 mos	2 mos	4 mos	6 mos	12 mos	15 mos	18 mos	19-23 mo	2-3 yrs	4-6 yrs
Vaccine											
Hepatitis B											
Rotavirus											
Diphtheria, Tetanus, Pertussis											
Haemophilus Influenzae type B											
Pneumococcal											
Inactivated Poliovirus											
Influenza											
Measles, Mumps, Rubella											
Varicella											
Hepatitis A											
Meningococcal											

TB Test (if required) *please circle* Positive Negative Date _____
 Signature or Stamp of a physician or public health personnel verifying immunization information above.
 Signature _____ Date _____

Allergies or Special Medical Concerns:
 _____ The above child does not suffer from any allergies at this time.
 _____ The above child has an allergy and the allergy emergency plan has been completed.
 All other special medical concerns that require a caregiver's attention must include a description and instructions.

IF YOUR CHILD ATTENDS PUBLIC SCHOOL: I hereby state that my child attends the following school where their shot records, vision and hearing tests, are current and on file.
 _____ West Columbia Elem. 711 South Gray Street West Columbia, TX 979-345-5191
 _____ Barrow Elementary 1112 Gaines Street. Brazoria, TX 979-799-1740
 _____ Other: School: _____ Address: _____, _____ Phone: _____
 Parents Signature: _____ Date: _____