ST. ANDREW'S PRESBYTERIAN CHILDREN PLACE
IMMUNIZATION RECORD AND PHYSICIAN'S STATEMENT
FAX: 713-667-1734

Child's Full Name___________________________________ Birth date_________________________

The following statement must be signed by a licensed physician prior to admission:
I have examined the above-named child within the past 6 months and find that he/she is physically able to take part in the program at St. Andrew's Children's Place.

____ ____
Physician's Signature Date

Please note the month, day, and year the above-named child received each immunization.

DTP __________ __________ __________ __________ __________

Polio __________ __________ __________ __________

HibCV __________ __________ __________ __________

Varicella (chicken pox) __________ ___________ or ____________
Date of Illness

Measles __________ __________ or____
Date of Illness (Physician's verification required)

Mumps __________ __________ or____
Date of Illness (Physician's verification required)

Rubella __________ __________

Hep. A __________ __________

Hep. B __________ __________ __________

Prevnar (PCV 7) __________ __________ __________ __________

Vision Screening (required for children 4 years and older) Results_________________________________

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Date Type of Screening Screener

Hearing Screening (required for children 4 years and older) Results________________________________

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Date Type of Screening Screener

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. 1/10