

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

Child's Full Name \_\_\_\_\_ Birthdate \_\_\_\_\_

**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 \_\_\_\_\_

Date	Type of Screening	Screener
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Hearing Screening (required for children 4 years and older) Results \_\_\_\_\_

Date	Type of Screening	Screener
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**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. 1/06