



Willow Bend Learning Center
 3900 W. Park Blvd.; Plano, TX. 75075
 Ph: 972-867-1871 Fax: 972-964-7097

HEALTH REQUIREMENTS					
Name of Child: _____				Date of Birth: _____	
IMMUNIZATIONS	Date / dose 1	Date / dose 2	Date / dose 3	Date / dose 4	Date / booster
DTP / DTaP / DT					
POLIO IPV or OPV					
MMR Rubella / Serampion					
PCV/Prevnar					
Hib					
Hepatitis A					
Hepatitis B					
TB TEST (if required)	<input type="checkbox"/> Positive	<input type="checkbox"/> Negative	Date: _____		
Varicella (see below)					
Other					

Varicella (chickenpox) vaccine **is not required if your child has already had chickenpox**. 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 of Health Care Professional _____ Date _____

For additional information regarding immunizations contact the Department of State Health Services at
http://www.dshs.state.tx.us/immunize/school_info.htm

ADMISSION REQUIREMENT: If your child does not attend pre-kindergarten or school away from the child-care operation, one of the following must be presented when your child is admitted to the child-care operation or within one week of admission. Please check only one option:

1. **HEALTH-CARE PROFESSIONAL'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.

Health Care Professional's Signature _____
Date

2. A signed and dated copy of a health care professional's statement is attached.

Name and address of health care professional:

Signature - Parent or Legal Guardian _____
Date

3. Medical diagnosis and treatment conflict with the tenets and practices of a recognized religious organization, which I adhere to or am a member of; I have attached a signed and dated affidavit stating this.

VISION	R 20/ _____	L 20/ _____	<input type="checkbox"/> PASS <input type="checkbox"/> FAIL
SIGNATURE _____		DATE _____	
HEARING	1000 Hz	2000 Hz	4000 Hz
R			
L			
SIGNATURE _____			<input type="checkbox"/> PASS <input type="checkbox"/> FAIL
DATE _____			

Signature – Parent or Legal Guardian: **X** _____

Date: _____