Willow Bend Learning Center

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HEALTH REQUIREMENTS

Name of Child: **Date of Birth**:

AGE ► VACCINE▼	Birth	1 mos	2 mos	4 mos	6 mos	12 mos	15 mos	18 mos	19-23 Mos	2-3 Yrs	4-6 Yrs
Hepatitis B											
Rotavirus											
Diphtheria, Tetanus, Pertussis											
Haemophilus influenzae type b											
Pneumococccal											
Inactivated Poliovirus											
Influenza											
Measles, Mumps, Rubella											
Varicella											
Hepatitis A											
Meningococcal											
TB TEST *(if required)*	☐ +ve	☐ -ve					*Date:* _____				

Signature or stamp of a physician *(or public health personnel verifying* ***immunization information*** *above)*

_____ _____
Signature of Physician ***Date***

Varicella (chickenpox) vaccine is not required if your child has had chickenpox disease. If your child has had chickenpox, please complete the statement: My child **has had varicella disease** (chickenpox) on or about **(date)** _____ and **does not need** varicella vaccine.

Parent's signature (for varicella statement only): _____ ***Date:*** _____
Signature of Parent (Varicella only)

☐ I am excluding my child from the immunization requirements for reasons of conscience, including a religious belief. I have attached an official notarized affidavit form developed and issued by the Department of State Health Services. I understand this affidavit is valid for 2 years.

For additional information regarding immunizations contact the Department of State Health Services at www.dshs.state.tx.us/immunize/public.shtm

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 able to take part in the day care program.

_____ _____
Signature of Health Care Professional ***Date***

2. ☐ **ATTACHED STATEMENT:** A signed and dated copy of a health care professional's statement is attached.

3. ☐ **RELIGIOUS AFFIDAVIT:** 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.

4. ☐ **HEALTH STATEMENT BY PARENT:** My child has been examined by a health care professional within the past year, and is able to participate in the day care program. Within 1 month of admission, I will obtain a health care professional's signed statement and submit to WBLC.

Name and address of health care professional: _____

_____

Signature - Parent or Legal Guardian (for health statement only) _____ ***Date:*** _____

VISION	R 20/ _____	L 20/ _____	☐ PASS ☐ FAIL

Signature of Health Care Professional: _____ ***Date:*** _____

HEARING	1000 Hz	2000 Hz	4000 Hz	☐ PASS ☐ FAIL
R				
L				

Signature of Health Care Professional: _____ ***Date:*** _____

Signature – Parent or Legal Guardian: _____ Date: _____