

PHYSICIANS STATEMENT

Child's Name _____

Date of Birth _____

Health Examination

A complete physical was given on _____ (date).

Physician's Recommendation:

_____ This child may be admitted to a child care facility.

_____ Other (explain)

Physician's Signature _____

Address _____

Phone (_____) _____ Date _____

DOCUMENTATION OF VARICELLA (CHICKENPOX) ILLNESS

1. A written statement from a physician or the child's/student's parent or guardian:

"This is to verify that _____ had varicella disease (chickenpox) on or about _____ and does not need varicella vaccine.

Parent/ or Guardian Signature Relationship to student

Date _____

2. Or by serologic confirmation of varicella immunity.

VISION AND HEARING EVALUATION

(Must be completed for children enter PreK & Kinder)

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 _____			