

PLEASE ATTACH A COPY OF YOUR CHILD'S IMMUNIZATION RECORDS

***The following immunizations are mandated by state law:

***THESE IMMUNIZATIONS MUST BE COMPLETED BEFORE REGISTRATION WILL BE CONSIDERED COMPLETE

Four basic does of Diphtheria, Peruses (Whooping Cough, and Tetanus (DPT); or Diphtheria-Tetanus (DT), or Tetanus in any combination are required. (The 4th dose must be administered on or after the fourth birthday). Three doses of Oral Polio (OPV) are required. Three doses of Hepatitis B Vaccine. One dose of Varivax (Varicella/Chicken Pox Vaccine) or proof of disease.

***The following immunizations are required after fifteen months of age:

Two doses of Measles (Rubeola), German Measles (Rubella), and mumps Vaccine (MMR), these vaccines are usually given as one vaccine, the second MMR is usually given during your child's five year physical.

Other immunizations: Smallpox: _____ HIB: _____

Date of Tuberculin Skin Test _____ / Results: _____

Date of Last Chest X-Ray _____ / Results: _____

Has your child had any childhood illness" Please list giving dates and complications: _____

Does your child have, or has he/she had: (Please Circle)

Vision Loss Yes No

Eye Disease Yes No

If yes, does your child wear glasses or contacts Yes No

Hearing Loss Yes No

If yes, does your child wear a hearing aid? Yes No

Earaches Yes No Head injury Yes No

Convulsions Yes No Headaches Yes No

Epileptic Seizures Yes No Diabetes Yes No

Asthma Yes No

Is your child receiving dental care Yes No

Is your child currently taking any long term medication? Yes No

If yes, explain: _____

HAS YOUR CHILD HAD ANY OF THE FOLLOWING: (Give date and details):

Allergy: _____

Recurring illness: _____

Serious accidents: _____

Emotional problems: _____

Recent loss of loved one or pet: _____

Parent Signature: _____

Date: _____