



HEALTH REQUIREMENTS

Child's Name _____ Birth Date _____

*Please complete chart below **OR** attach copy of immunization records.*

Immunizations	Date: 1st Dose	Date: 2nd Dose	Date: 3rd Dose	Date: 1st Booster	Date: 2nd Booster
DTP/DTaP/DT					
Polio					
Hib					
Pneumococcal					
MMR					
Varicella					
Hepatitis A					
Hepatitis B					

NOTE: You may submit a copy of an immunization record signed or stamped by a physician or health professional.

Tuberculosis Test: To be completed if recommended for the area by the Texas Department of Health.

TUBERCULOSIS TEST RESULTS: Positive Negative

Physician's Health Statement

We consider this child to be up-to-date on immunizations and able to participate in the child care center program at this time.

Signature (or stamp) - Physician or Health Professional

Date

Signature - Staff Making handwritten copy of record

Date