CERTIFICATE OF IMMUNIZATION AND HEALTH RECORD

(TO BE COMPLETED AND SIGNED BY CHILD'S PHYSICAN)

Child's Name_____ **Birth Date**_____

Immunization History: (Date Received)

Polio **1**_____ **DTaP** **1**_____ **HIB** **1**_____ **Hep B** **1**_____

2_____ **2**_____ **2**_____ **2**_____

3_____ **3**_____ **3**_____ **3**_____

Varicella **1**_____ **MMR** **1**_____

PCV **1**_____ **2**_____ **3**_____ **4**_____

Medical History:

Chicken Pox _____ **Asthma** _____ **Heart Trouble** _____

Seizures _____ **Scarlet Fever** _____ **Bladder/Bowel** _____

Diabetes _____ **Kidney** _____

Allergies/Intolerances (specify) _____
_____

Other_____

Routine Medications? Yes_____ **No**_____ **If yes, explain**_____
_____

Is there any medical reason the child's activity at the Preschool should be limited?
Yes_____ **No**_____ **If Yes 'explain**_____

What is the general condition of the child's health?_____

Date the child was last examined by a Physician_____

Dated_____ **Physician's Signature**_____