



Health Form

| | |
|---------------|----------------|
| Child's Name: | Date of Birth: |
|---------------|----------------|

Health Requirements for Children:

1. Evidence must be presented for each child upon entering care that he/she is physically able to take part in our program.
2. At the beginning of each school year thereafter, evidence must be presented that the child continues to be able to participate in our program.
3. **A current immunization record for each child must be maintained at our facility.** When your child receives additional doses or boosters, you must update his/her record immediately. These records are audited regularly by the Texas Department of Health.

Admission Requirement:

One of the following must be presented when your child is admitted to our facility. Check to indicate the option you select:

A written statement from a licensed physician, signed and dated, certifying that the physician has examined your child within the past year and that the child is physically able to take part in our program.

"I have examined the above-named child within the past year and find that he/she is physically able to take part in your program.

Physician's Signature

Date

A form or written statement from a health service or clinic. Please attach it to this form.

If you do not have one of the above, please select from the following options:

A signed statement from the parent as follows: "My child has been examined within the past year is able to participate in your program. My child was examined by

Physician's Name

located at _____
Physician's Address and Phone Number

I will submit a signed and dated physician's statement as described above, within 12 months of the date of admission."

Signature of Parent or Legal Guardian

Date

"My child has an appointment for a physical examination on _____ with _____
Date Physician's Name

_____. I will submit the physician's statement immediately."
Address, and Phone Number

Signature of Parent or Legal Guardian

Date

NOTE: If medical diagnosis and treatment and/or immunization conflict with your religious beliefs, you must sign a notarized affidavit to that effect and attach it to this form. If immunization would be injurious to your child or family, you must obtain a certificate signed by a physician to that effect and attach it to this form.

Vision and Hearing Screenings (required for four- and five-year-old children):

| | | | | | |
|-------------------|------|-------|--------------------|------|-------|
| Vision Screening: | Left | Right | Hearing Screening: | Left | Right |
|-------------------|------|-------|--------------------|------|-------|

Signature or Stamp—Licensed Physician or Health-Care Professional

Date

Medical History (to be filled out by parent)

| | | |
|---|----------------|----|
| Child's Name: | Date of Birth: | |
| Does your child have an existing illness or illnesses? | Yes | No |
| If YES, please describe: | | |
| Has your child had a previous serious illness or illnesses? | Yes | No |
| If YES, please describe: | | |
| Has your child ever been hospitalized? | Yes | No |
| If YES, please describe: | | |
| Does your child have any allergies to foods, animals, pollens, molds, medications, etc? | Yes | No |
| If YES, please describe: | | |
| List any medications prescribed for your child's continuous and/or long-term use: | | |

Your child cannot attend Carpe Diem Private Preschool until you have submitted his/her current immunization record validated by a physician or other health-care professional, as specified by the Texas Department of Health.

Parent Signature

Date

Print Name