**Physician’s Statement**

Name of Child \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*I have examined the above child within the past year and find that he/she is able to take part in the preschool program.*

Health Care Professional Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_\_\_\_\_\_ Zip \_\_\_\_\_\_\_\_\_\_\_\_\_

Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Age  Vaccine | Birth | 1 mos | 2 mos | 4 mos | 6 mos | 12 mos | 15 mos | 18 mos | 19-23 mo | 2-3 yrs | 4-6 yrs |
| Hepatitis B |  |  |  |  |  |  |  |  |  |  |  |
| Rotavirus |  |  |  |  |  |  |  |  |  |  |  |
| Diphtheria, Tetanus, Pertussis |  |  |  |  |  |  |  |  |  |  |  |
| Haemophilus  Influenzae type B |  |  |  |  |  |  |  |  |  |  |  |
| Pneumococccal |  |  |  |  |  |  |  |  |  |  |  |
| Inactivated Poliovirus |  |  |  |  |  |  |  |  |  |  |  |
| Influenza |  |  |  |  |  |  |  |  |  |  |  |
| Measles, Mumps, Rubella |  |  |  |  |  |  |  |  |  |  |  |
| Varicella |  |  |  |  |  |  |  |  |  |  |  |
| Hepatitis A |  |  |  |  |  |  |  |  |  |  |  |
| Meningocccal |  |  |  |  |  |  |  |  |  |  |  |

TB Test (if required) *please circle* Positive Negative Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature or Stamp of a physician or public health personnel verifying immunization information above.

Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Varicella (chickenpox) vaccine is not required if your child has had chickenpox disease. If you child has had chickenpox, please complete the statement: My child had varicella (chickenpox) on or about (date) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

and does not need varicella vaccine.

Parent Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Complete ONLY if Applicable*

I am excluding my child from the immunization requirements for reasons of conscience, including a religious belief. I have attached an official notarized affidavit form developed and issued by the Department of State Health Services. I understand this affidavit is valid for 2 years.

Medical diagnosis and treatment conflict with the tenets and practices of a recognized religious organization, which I adhere to or am a member of; I have attached a signed and dated affidavit stating this.

Parent Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_