CERTIFICATE OF IMMUNIZATION

Student's Name:____ **Date of Birth:**___________________

IMMUNIZATIONS	RECORD COMPLETE DATES (month, day, year) OF VACCINE DOES GIVEN				
Diphtheria, Tetanus, Pertussis (DTP, DTAP)	1	2	3	1	1
Poliomyelitis (OPV or IPV)	1	2	3		
Haemophiulus Influenza Type b (Hib conjugate Vaccine)	1	2	3		
Measles, Mumps, Rubella (MMR vaccine)	1	2	Other(List type and date received):		
Hepatitis A Vaccine	1	2	3	Other:	
Hepatitis B Vaccine (HBV)	1	2	3	4	
Varicella Vaccine	1	2	Other:		
Rotavirus Vaccine	1	2	3	Other	
Pneumococcal	1	2	3	4	

MEDICAL EXEMPTION: I certify that the administration of the vaccine(s) designated below would be determinal to the student's health. The vaccine(s) is (are) specifically contraindicated because (please specify):

____

____

____

DTP/DtaP:[__]; OPV/IPV:[__]; Hib:[__]; MMR:[__];Hepatitis A:[__];Hepatitis B:[__]; Varicella:[__];Rotavirus:[__]; Pneumococcal:[__];

This contradiction is permanent [__] or temporary [__] and expected to precluse immunization until: Date (M,D, Y): |___|___|___|

Signature of Physician or Health Department Official: ________________________________ **Date (M,D, Y): |___|___|___|**

RELIGIOUS EXEMPTION: Policy allows a child an exemption from receiving immunizations required for a school attendance if the student of the student's parent/guardian submits an affidavit to the school's admitting official stating that the administration of immunizing agents conflicts with the student's religious tenets or practices. Any student entering school must submit this affidavit on a CERTIFICATE OF RELIGIOUS EXEMPTION, which may be obtained from any local health department or department of social services.

ADMISSION REQUIREMENT: If your child does not attend pre-kindergarten or school away from the child-care operation, one of the following must be presented when your child is admitted to the child-care operation

Please check only one option:

1. ☐ HEALTH-CARE PROFESSIONAL'S STATEMENT: I have examined the above named child within the past year and find that he / she is able to take part in the school program.

   ____ ________________________
   Health Care Professional's Signature Date

2. ☐ A signed and dated copy of a health care professional's statement is attached.

Student's Name:____ Date of Birth:__________________

Required Screening Test	Explanation	Result		
Vision Screen (4 Yr. & above)	Distance visual acuity without correction	Right: 20/	Left: 20/	Both: 20/
	Distance visual acuity with correction	Right: 20/	Left: 20/	Both: 20/
Hearing Screen (4 Yr. & above)	Right:		Left:	
Vision and hearing screenings are required by the Special Senses and Communication Disorders Act for all students in prekindergarten.				

Vision Screening:
Child to be prescreened? Yes: [__] No: [__] Child to be prescreened? Yes: [__] No: [__]
Hearing:
Child to be prescreened? Yes: [__] No: [__] Child to be prescreened? Yes: [__] No: [__]

Condition	Yes	No	Comments if "Yes"
Allergies (food, Insects, drugs, latex)			
Allergies (seasonal)			
Asthma or breathing problems			
Attention-Deficit/Hyperactivity Disorder			
Behavioral problems			
Bladder problems			
Bleeding problems			
Bowel problems			
Cerebral Palsy			
Cystic Fibrosis			
Dental problems			
Developmental problems			
Diabetes			
Head or spinal injury			
Hearing problems or deafness			
Heart problems			
Hospitalizations (when, why)			
Lead poisoning			
Muscular problems			
Seizures			
Sickle Cell Disease (not trait)			
Speech problems			
Surgery			
Vision problems			
Other:			

List all prescription and over the counter medications your child takes regularly: ___________________________________
____
____

Describe any other important health-related information about your child (i.e., feeding tube, oxygen support, hearing aid, etc): ____
____
____

Name of your child's pediatrician or primary care provider: ____

Names of medical specialists or special clinics caring for your child: ________________________________
____

Has your child ever seen a dentist? Yes: [__] No: [__] If yes, date of last appointment: __________________________

Check here if you want to discuss confidential information with the Get Well Place nurse or school authority: Yes: [__] No: [__]

Check here if you give permission for the Get Well Place nurse of other school authority to contact the examining physician to discuss any information contained on this form: Yes: [__] No: [__]

____ ______________________________
Signature – Parent or Legal Guardian Date