



IMMUNIZATION & HEALTH REQUIREMENTS

Child's Name				Date of Birth			
IMMUNIZATIONS	DATE ADMINISTERED	DATE ADMINISTERED	DATE ADMINISTERED	DATE ADMINISTERED	DATE ADMINISTERED		
Hep-B Hepatitis B							
DTaP Diphtheria, Tetanus, Pertussis							
Hib Haemophilus Influenza							
IPV Polio							
PCV7 Pneumococcal Conjugate							
MMR Measles, Mumps, Rubella			Physician's Verification Must be Submitted Date of Illness: <table border="1" style="display: inline-table; margin-left: 20px;"> <tr> <td style="width: 50px; height: 30px;">Measles</td> <td style="width: 50px; height: 30px;">Mumps</td> </tr> </table>			Measles	Mumps
Measles	Mumps						
Hep-A Hepatitis A							
Chicken Pox Varicella							

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

Signature of Physician or Health Care Professional	Date	Signature of Staff making handwritten copy of record	Date
Printed name of Physician or Health Care Professional			

ADMISSION REQUIREMENT: One of the following must be presented when your pre-school child is admitted to MCDS. Please check below to indicate the option you select:

Doctor's statement: I have examined the above-named child within the past year and find that he/she is physically able to participate in the day care program.

Physician's Signature	Date
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A copy of the medical screening form from the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program if no referral for further diagnosis and treatment is required.

A form or written statement from health service or clinic.
 Vision and hearing testing is required for all children 4, 5, 6, 8 & 10 years of age as of September 1st. Testing must be done by a certified professional and results kept in the child's permanent file.

IF YOU DO NOT HAVE ANY OF THE ABOVE ADMISSION REQUIREMENTS:

Parent's statement: My child has been examined within the past year by a licensed physician and is able to participate in the day care program.

Name and Address of Physician **OR** of EPSDT screening site:

Within the next twelve (12) months, I will submit to MCDS either (a) a physician's statement, (b) a copy of the medical screening form from the EPSTD Program, or (c) a statement from a health service or clinic.

OR, my child has an appointment for a physical examination on this date: _____

Name and Address of Physician **OR** of EPSDT screening site:

My signature below indicates my commitment to submit a physician's statement or an EPSDT, health service or clinic form to MCDS following the examination.

Signature of Parent or Legal Guardian	Date
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Note: If medical diagnosis and treatment and/or immunization and TB testing conflict with your religious beliefs, you must sign an affidavit to that effect and attach it to this form. If Immunizations and TB testing would be injurious to your child or your family, you must obtain a certificate (signed by a physician) to that effect and attach it to this form.