Montessori Country Day School
5117 LaBranch
Houston, TX 77004

ph: 713-520-0738
fax: 713-524-0569
montessorihouston.com

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					
Hep-A Hepatitis A					
Chicken Pox Varicella					

Physician's Verification Must be Submitted

Date of Illness:	**Measles**	**Mumps**

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**

_____ 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

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.*

Revised 9/18/2006
MCDSforms