

ST. BARTHOLOMEW CATHOLIC PRESCHOOL HEALTH STATEMENT

Name of Child: _____	Date of Birth: _____
<p style="text-align: center;">HEALTH-CARE PROFESSIONAL'S STATEMENT: <i>I have examined the above named child within the past year and find that he / she is able to take part in the preschool program.</i></p> <p>Health Care Professional Name _____</p> <p>Address _____</p>	
Health Care Professional Signature: _____	Date: _____

Check one:

- My child is younger than 4 years old and therefore does not require vision and hearing screening.
OR
- My child is 4 years or older and their vision and hearing screening results are marked below.

VISION	R 20/ _____	L 20/ _____	<input type="checkbox"/> PASS <input type="checkbox"/> FAIL
HEARING	1000 Hz	2000 Hz	<input type="checkbox"/> PASS <input type="checkbox"/> FAIL
R			
L			
Health Care Professional Signature: _____			Date: _____

Signature – Parent or Legal Guardian

Date

ST. BARTHOLOMEW CATHOLIC PRESCHOOL IMMUNIZATION RECORD

Name of Child:							Date of Birth:				
Age ► Vaccine ▼	Birth	1 mos	2 mos	4 mos	6 mos	12 mos	15 mos	18 mos	19-23 Mos	2-3 Yrs	4-6 Yrs
Hepatitis B											
Rotavirus											
Diphtheria, Tetanus, Pertussis											
Haemophilus influenzae type b											
Pneumococcal											
Inactivated Poliovirus											
Influenza											
Measles, Mumps, Rubella											
Varicella											
Hepatitis A											
Meningococcal											
Signature or stamp of a physician or public health personnel verifying immunization information above.											
							_____ Physician Signature			_____ Date	

Varicella (chickenpox) vaccine is not required if your child has had chickenpox disease. If your child has had chickenpox, please complete the following statement: *My child had varicella disease (chickenpox) on or about (date of chickenpox) _____ and does not need the varicella vaccine.*

Parent signature _____ Date _____

Signature – Parent or Legal Guardian

Date