Physician's Name _____ Phone No. _____

SECTION I. Immunization Record

Child's Full Name _____ Birth Date _____

TO BE COMPLETED BY PHYSICIAN'S OFFICE

Please note the month, day, and year the above named child received each immunization.

Hepatitis B	_____	_____	_____		
Rotavirus	_____	_____	_____		
Pneumococcal	_____	_____	_____	_____	
Inactivated Poliovirus	_____	_____	_____	_____	
Diphtheria, Tetanus, Pertusis	_____	_____	_____	_____	_____
Haemophilus Influenzae Type B	_____	_____	_____	_____	
Measles, Mumps, Rubella	_____	_____			
Varicella	_____	_____	Date of Illness _____ (Physician's verification required)		
Hepatitis A	_____	_____			
Meningococcal	_____				
Influenza	_____	_____	_____	_____	_____

***Signature or stamp of a physician or public health personnel verifying immunization information above** _____ Signature _____ Date

SECTION II. Pre-K 4 Students Only

VISION R20/_____ L20/_____ Pass _____ Fail _____

HEARING	1000Hz	2000Hz	4000Hz	
Right	_____	_____	_____	Pass _____
Left	_____	_____	_____	Fail _____

_____ _____

Physician's Signature **Date**

SECTION III. First time applicants only

PHYSICIAN'S STATEMENT

Those enrolling in *A Children's Village* for the first time must have this completed by a licensed physician before your child attends class:

I have examined the above named child within the past year and find that he/she is physically able to take part in the program at *A Children's Village*.

_____ _____

Physician's Signature **Date**