BISHOP HOFFMAN CATHOLIC SCHOOL EARLY CHILDHOOD CENTER

CHILD MEDICAL STATEMENT

(Physician's form due within 30 days of admission) ***Date of Examination:*** _____

Child's Name:_____ Date of Birth:_____

Height: _____ Weight:_____

Limitations or Health condition (including allergies, medications,dietary restrictions)

Immunizations:	Circle one:		If Exemption from Immunizations, please state why:		
Complete for age:	Yes	No		Religious Conviction	Yes No
In Process	Yes	No			

This child has been examined and is in suitable conditon to participate in group class/ Child care.

Signature of examining Physician/Physicians Assistant/Advanced Practice Nurse : (circle one)

Physician's Address: _____

Physician's Phone Number: _____

Parent/Guardian: Please fill out below or attatch immunization record to this form. Thank You!

Please write in date when immunization was administered

	Birth	1 months		2 Month	4 months	6 months
Hepititis B	O HepB	O HepB				O HepB
Rotavirus				O RV	O RV	O RV
DTaP				O DTaP	O DTaP	O DTaP
Hib				O hib	O hib	O hib
PCV				O PCV	O PCV	O PCV
IPV				O IPV	O IPV	O IPV
Inluenza						O Flu (1st Dose O Second Dose
	12 months	**15 months**	**18 months**	**19-23 Months**	**2-3 Years**	**4 to6 Years**
Hepititis B	O HepB					
MMR	OMMR					O MMR
DTaP						O DTaP
Hib	O Hib					
PCV	O PCV					
IPV	O IPV					O IPV
Varicella	O Varicella					O Varicella
Influenza	O Flu- first dose O 2nd Dose (if needed)		Age 2 Age 3 O Flu- first dose O 2nd Dose (if needed)		Age 4 Age 5 Age 6 O Flu- first dose O 2nd Dose (if needed)	