Fair Haven Day School

Health Requirements • Date:_____

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CHILD'S NAME:			**DATE OF BIRTH:**		
*NOTE: You may submit a copy of an immunization record signed or stamped by a physician or health professional; however **the ADMISSION REQUIREMENT (below) must be completed by a health care professional***					
IMMUNIZATIONS	**Date / dose 1**	**Date / dose 2**	**Date / dose 3**	**Date / booster**	**Date / booster**
Diphtheria, Tetanus, Pertussis					
Polio					
Hib					
Hepatitis B					
Measles, Mumps, Rubella					
Hepatitis A					
Varicella (see below)					
Pneumococcal					
TB Test	Date:	Result: ( ) Pos. ( ) Neg.	Date:	Result: ( ) Pos. ( ) Neg.	

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

_____ _____
Signature – Parent or Legal Guardian Date

Signature (or stamp) of physician/health care professional _____ Date _____

Signature of staff making handwritten copy of record _____ Date _____

ADMISSION REQUIREMENT: One of the following must be presented when your child (under age 5) is admitted to the school or within one week of admission. Check to indicate the option you select:

( ) HEALTH CARE PROFESSIONAL'S STATEMENT: I have examined the above-named child within the past year and find that he/she is physically able to take part in the school program.

_____ _____
Physician's Signature **Date**

( ) A copy of the medical screening from the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program, if no referral for further diagnosis and treatment is indicated.

( ) A form or written statement from a health service or clinic.

If you do not have any of the above:

( ) PARENT'S STATEMENT: My child has been examined within the past year by a licensed physician and is able to participate in the school program.

Name and Address of health care professional:

( ) Within 12 months of admission, I will obtain a health care professional's statement and will submit it to the school.
OR
( ) My child has an appointment for a physical examination:

Date:	Name and address of health care professional:

I will submit the statement, from a health care professional, to the school facility following the examination.

_____ _____
Signature – 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 immunization and/or TB testing would be injurious to your child or family, you must obtain a certificate (signed by a health care professional) to that effect and attach it to this form.**