Chapelwood School for Young Children, 11140 Greenbay, Houston, TX 77024
Main Office 713-465-4657

MEDICAL FORM

TO BE COMPLETED BY A PHYSICIAN

CHILD'S NAME: ___________________________ **EXAM DATE:** __________

PLEASE ATTACH CURRENT IMMUNIZATION RECORD

Vaccines	Date	Date	Date	Date	Date
DTP, DTaP, DT, Td					
POLIO (IPV)					
HIB					
PNEUMOCOCCAL (PCV/PREVNAR)					
HEP A					
HEP B					
VARICELLA (VAR)					
MMR					

Please attach

** REQUIRED STATEMENT OF PHYSICAL PARTICIPATION**

This child has been examined by me and found to be free of infectious and contagious disease and is physically and mentally able to participate in school activities, unless listed under "Comments" to the contrary.

COMMENTS: ____

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* If Yes, explain in Comment section to the right.	* Yes	No
Cardiovascular		
Abdomen		
Neuro		
Respiratory		
GU		
Musculoskeletal		
HEENT		
Skin		

COMMENTS: ______________________________

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____

Doctor's Name: ____ **Phone:** ____________________

Address ____

PHYSICIAN'S SIGNATURE: ____ **Date:** __________