WAYA PRESCHOOL

# Medical Health Statement

| To be completed by parent | |
|---|---|
| Child's Name: | DOB: |
| Parent's Name: | |
| Physician's Name: | |
| Return by email to: assistantdirector@waya.org or fax to: 512-477-2926 | |

| To be completed by Physician | | | | | |
|---|---|---|---|---|---|
| **Immunizations** ***Please show Month/Day/Year*** or attach a copy with signature from Dr. | | | | | |
| Influenza | | | | | |
| DTaP | | | | | |
| Polio (IPV) | | | | | |
| PCV | | | | | |
| HiB | | | | | |
| Rotavirus (RV) | | | | | |
| Hep B | | | | | |
| Hep A | | | | | |
| MMR | | | | Varicella | |

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| Are there any restrictions to normal physical activities indicated? |
| Does any chronic medical condition necessitate dietary supplements, restrictions or medications? |
| Known allergies: |
| Date of last examination: |

We consider this child to be up-to-date on immunizations and able to participate in the child care center program at this time.

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Child's Primary Physicians Signature Date Signed