

**Buda Methodist Child Care Center  
Physician Statement  
& Health/Immunization Records**

This is a 2-part form. This form must be completed and turned into the office prior to your child's first day of attendance at the center. If this form is not signed by a health care professional, your child will be unable to remain at the center. It is a State requirement that a health care professional's signature acknowledging good health be signed and dated within the last 12 months. **THIS FORM MUST BE TURNED IN BEFORE YOUR CHILD CAN BEGIN ATTENDANCE AT THE CENTER.**

CHILD'S NAME: \_\_\_\_\_ SEX: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

MOTHERS NAME: \_\_\_\_\_ FATHER'S NAME \_\_\_\_\_

PHYSICIAN NAME: \_\_\_\_\_

(1) (Please list full date-month/day/year-for each immunization below)

Immunization	Date/dose 1	Date/dose 2	Date/dose 3	Date/booster	Date/booster
Hepatitis B					
DTP/DTap/Dt					
Hib					
Polio:IPV/OPV					
MMR					
Varicella					
PCV					
Hepatitis A					
Other					
Influenza					

(2) I have examined the above named child in the past year and have found him/her to be physically fit to attend Buda Methodist Child Care Center.

\_\_\_\_\_  
Physician/Health Care Professional Signature (Required)

\_\_\_\_\_  
Date of Last Examination  
(must be in the last 12 months)

Vision	R20/ _____		L20/ _____		Pass ____ Fail ____
Signature _____	Date _____				
Hearing	1000 Hz	2000Hz	4000Hz		Passed ____
					Failed ____
Signature _____	Date _____				