St. Mary's Clinton Preschool

HEALTH CERTIFICATE

(Must be completed and returned no later than September 1st.)

Child's Name____DOB___/___/___

Last seen in Doctor's Office:____/____/____Hgt_________Wgt_________BMI________

Dates of Immunizations:

Hepatitis B	H Influenzae Type B	MMR
HB-1___/___/___	(1)___/___/___	(1)___/___/___
HB-2___/___/___	(2)___/___/___	(2)___/___/___
HB-3___/___/___	(3)___/___/___	
	(4)___/___/___	Varicella (Chicken Pox)
Flu Shot___/___/___		(1)___/___/___
		(2)___/___/___

Diptheria, Tetanus, Pertussis	Inactivated Polio Vaccine	Conjugated Pneumococcal Vaccine
(1)___/___/___	(1)___/___/___	(1)___/___/___
(2)___/___/___	(2)___/___/___	(2)___/___/___
(3)___/___/___	(3)___/___/___	(3)___/___/___
(4)___/___/___	(4)___/___/___	(4)___/___/___
(5)___/___/___		

Other immunizations may include the recommended vaccines of Rotavirus, Influenza, & Hepatitis A:

Type of immunization	Date	Type of immunization	Date

Does your child have a history of any of these health issues? Please give details.

1. ___Allergies/Asthma____
2. ___Medications____
3. ___Vision Problems/Glasses______________________________________
4. ___Hearing/Ear Complications____________________________________
5. ___Speech Impediment____
6. ___Premature Birth____
7. ___Heart Condition____
8. ___Head Injury____
9. ___Behavior/Anxiety Disorder____________________________________
10. ___Serious/Chronic Illness______________________________________
11. ___Serious Head Injury____
12. ___Hospitalization____
13. ___Surgery____
14. ___Tuberculosis (include exposure family)___________________________
15. ___Developmental Conditions____________________________________

Date of Last Dental Exam: ___/___/____ Lead Screening: ___/___/___

Tuberculin Test Date____/____/____ Mantoux Results: •positive •negative

Please note any concerns regarding your child's needs in the school setting:

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Physician's Signature_____________________________________Date___/___/___

Physician's Name (print)__________________________________Phone_______________