The Apple Tree School
17127 Red Oak Dr.
Phone: 281-444-6707
Fax: 281-444-8884

Health Requirements & Immunization Record 2017 - 2018

Child's Name:_____ D.O.B.: _____

Immunizations	Date - 1st Dose	Date - 2nd Dose	Date - 3rd Dose	Date -1st Booster	Date -2nd Booster
DPT/Td					
Polio					
Hib-CV				**NOTE: You may submit a machine copy of an immunization record signed or stamped by a physician or health personnel.**	
Measles: Vacc.					
Mumps: Vacc.		**Physician's Verification Must Be Submitted**			
Rubella: Vacc.		**Pneumococcal Conjugate Date-1st Dose**		**Date-2nd Dose**	**Date-3rd Dose**

Tuberculosis Test: To be completed if recommended for the area by the Texas Department of Health. (Staff will inform you of these requirements)

Tuberculosis Test Results

☐ **Positive** ☐ **Negative** **Date:**_____

_____ _____ _____ _____

Signature (or stamp)-Physician or health Professional Date Signature - Staff making handwritten Copy of Record Date

ADMISSION REQUIREMENTS: One of the following must be presented when your pre-school-age child is admitted to Apple Tree School or within one week of admission. Check to indicate the option you select.

☐ Doctor'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 program at The Apple Tree School.

_____

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 program at The Apple Tree School. I will obtain a physician's statement, a copy of the medical screening form from the EPSDT Program, or a form or statement from a health service or clinic and will submit it to The Apple Tree School within 5 days upon enrollment.

_____

Name and Address of Physician OR Address of EPSDT Screening Site

☐ My child has an appointment for a physical examination. I will submit the physician's statement, EPSDT form, or health service or clinic form to The Apple Tree School following the examination.

_____

Date of Appointment / Name and Address of Physician OR Address of EPSDT Screening Site

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 physician) to that effect and attach it to this form.

_____ _____

Signature - Parent or Legal Guardian Date