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
HB-1___/___/___
HB-2___/___/___
HB-3___/___/___

Flu Shot___/___/___

H Influenzae Type B
(1)___/___/___
(2)___/___/___
(3)___/___/___
(4)___/___/___

MMR
(1)___/___/___
(2)___/___/___

Varicella (Chicken Pox)
(1)___/___/___
(2)___/___/___

Diptheria, Tetanus, Pertussis
(1)___/___/___
(2)___/___/___
(3)___/___/___
(4)___/___/___
(5)___/___/___

Inactivated Polio Vaccine
(1)___/___/___
(2)___/___/___
(3)___/___/___
(4)___/___/___

Conjugated Pneumococcal Vaccine
(1)___/___/___
(2)___/___/___
(3)___/___/___
(4)___/___/___

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:

_____

This child is free from communicable disease and able to participate in child day care. Yes☐No☐

Physician's Signature_____ Date___/___/___

Physician's Name (print)_____ Phone_____