YORKSHIRE ACADEMY
2018/19
IMMUNIZATION RECORD/STATEMENT of HEALTH

Name:_____ D.O.B.: _____

Parent/Guardian: _____ Sex: _____

Hepatitis (HepB)					
Rotavirus (RV)					
DTP/DTaP					
Hib					
Pneumococcal (PCV)					
Polio (IPV)					
MMR					
Varicella					
Hepatitis A					
Meningococcal (MCV)					
Influenza					
Other					

Date child had Chicken Pox: _____

Drug Allergies:_____

Vision Testing: _____ **Hearing Testing:** _____
*Vision & screening is required for **all** Pre-K, Kindergarten, 1st, 3rd, 5th and new students going into 2nd & 4th.*

Comments: _____

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Physician's Statement

The above-named person has been examined by me on _____, and has been found to be in good health and free of contagious disease unless listed above under "Comments"

_____ _____ _____
Physician's Signature Phone Date

The Physician must sign this form before it is returned to school.

Parent's Statement:

My child has been examined within the past year by a licensed physician and is able to participate in the daycare/school program

_____ _____
Signature of Parent or Legal Guardian Date

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