

# WIND 'N WILLOW PRESCHOOL CENTER

## Immunizations

CHILD'S NAME \_\_\_\_\_ DOB \_\_\_\_/\_\_\_\_/\_\_\_\_ EXAM DATE \_\_\_\_/\_\_\_\_/\_\_\_\_

If one or more of the required medical immunizations is deemed detrimental to this child's health, attach certificate specifying which immunization(s) and complete and sign medical exemption on back of form.

*Include all dates*

DPT	1 <sup>st</sup>	2 <sup>nd</sup>	3 <sup>rd</sup>	Booster	Booster
POLIO	1 <sup>st</sup>	2 <sup>nd</sup>	3 <sup>rd</sup>	Booster	Booster
HIB	1 <sup>st</sup>	2 <sup>nd</sup>	3 <sup>rd</sup>	4 <sup>th</sup>	
HEPATITIS B	1 <sup>st</sup>	2 <sup>nd</sup>	3 <sup>rd</sup>		
MMR	1 <sup>st</sup>	2 <sup>nd</sup>			
VARIVAX					

*Other Immunizations*

PREVNAR	Date	Date	Date
TYPE	Date	Date	Date
TYPE	Date	Date	Date
TYPE	Date	Date	Date

### TESTS

Date	Tuberculin Test		
	POS _____	NEG _____	Tine _____ Mantoux _____
	Results		Specify

If positive, attach physician's statement documenting treatment and follow-up.

HEALTH SPECIFICS	COMMENTS:
____ Yes ____ No Are there allergies? (Specify)	
____ Yes ____ No Is medications regularly taken? (Specify drug and condition)	
____ Yes ____ No Is specific diet required? (Specify diet and condition)	
____ Yes ____ No Are there any hearing visual or dental conditions requiring special attention?	
____ Yes ____ No Are there any medical or developmental conditions requiring special attention?	

SUMMARY OF PHYSICAL EXAM (including special recommendations to Wind 'n Willow):

\_\_\_\_\_

\_\_\_\_\_

On the basis of my finding as indicated above and on my knowledge of the above named child, I find that (s)he is free from contagious and communicable disease \_\_\_\_ Yes \_\_\_\_ No and is able to participate in preschool. \_\_\_\_ Yes \_\_\_\_ No

\_\_\_\_\_  
Signature of Examiner

\_\_\_\_\_  
Address

\_\_\_\_\_  
Name Please Print

\_\_\_\_\_

\_\_\_\_\_  
Date

\_\_\_\_\_  
Phone Number