Please Return This Form To Your Child's Teacher Before or On Parent Orientation Night

UNITED CHURCH PRESCHOOL
CERTIFICATE OF IMMUNIZATION AND MEDICAL RELEASE

To be completed by physician:

Child's Name: _____ Sex: _____
Address: _____ Birthdate: _____

IMMUNIZATION REQUIRED FOR SCHOOL ATTENDANCE (full dates required)

DtaP/DTP/DT/Td				
Polio/OPV/IPV				
Mumps				
Measles				
Rubella				
MMR				
Hib				
Hepatitis B				
Varicella/Varivax				
T.B. Test Result				

1. Does this child have any physical, mental, or emotional handicap(s) that could affect his/her participation in the United Church Preschool, or that of his/her classmates? If so, please specify:

_____
_____
_____

2. Does this child take any medication on a daily basis? If so, please specify:

_____
_____
_____

3. Does this child have any allergies? If so, please specify:

_____
_____
_____

Physician Name: _____ Phone: _____

Address: _____

Signature of Physician: _____ Date: _____