ROCKING HORSE DAY CARE CENTERS

PHYSICIAN'S STATEMENT & HEALTH / IMMUNIZATION RECORDS

THIS FORM MUST BE COMPLETED AND TURNED INTO THE FRONT DESK PRIOR TO YOUR CHILD'S FIRST DAY OF ATTENDANCE AT THE CENTER. IT IS A STATE REQUIREMENT THAT A HEALTH CARE PROFESSIONAL'S SIGNATURE ACKNOWLEDGING GOOD HEALTH BE SIGNED AND DATED WITHIN THE LAST 12 MONTHS.

CHILD'S NAME: _____ D.O.B.: _____ Sex: ____

ADDRESS: _____

PHYSICIAN'S NAME: _____

PLEASE LIST FULL DATE-MONTH/DAY/YEAR - FOR EACH IMMUNIZATIION BELOW

IMMUNIZATION	DATE / DOSE 1	DATE / DOSE 2	DATE / DOSE 3	DATE / BOOSTER 1	DATE / BOOSTER 2
HEPATITIS B					
DTP/DTAP/DT					
HIB					
POLIO:IPV/OPV					
MMR					
VARICELLA					
PCV					
HEPATITIS A					
OTHER					
INFLUENZA					

I HAVE EXAMINED THE ABOVE NAMED CHILD IN THE PAST YEAR AND HAVE FOUND HIM / HER TO BE PHYSICALLY FIT TO ATTEND ROCKING HORSE DAY CARE CENTERS.

PHYSICIAN SIGNATURE: _____

DATE OF LAST EXAM (MUST BE WITHIN THE LAST 12 MONTHS): _____

VISION R20 / _____ L20 / _____ PASS: _____ FAIL: _____

HEARING 1000 HZ 2000 HZ 4000 HZ PASS: _____ FAIL: _____

PHYSICIAN SIGNATURE: _____ DATE: _____