PHYSICIAN'S STATEMENT FOR BOWEN ROAD DAY SCHOOL

Child's Name _____ _____ Birthdate _____

To be completed by physician:
Immunization records are required for admittance. Children may be provisionally admitted if immunizations are begun and and continued as soon as medically advisable.

	1	2	3	4	5
Hepatitis B					
Dtap					
Hib					
IPV					
MMR					
Varicella					
Pneumococcal					
Influenza					
Hepatitis A					
TB test		NEG ( ) POSITIVE ( )			

VISION SCREEN					
RT: 20/					
LT: 20/					
AUDIO SCREEN					
	1000	2000	3000	4000	
RT:					
LT:					

Date:

Chicken pox_____ Measles_____

Record of allergies to: _____(include any food, drug or other allergy.

List any continuous or long term medication: _____

Previous childhood diseases, illness or serious injuries: _____

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Please list any special recommendations or information which you feel the school should know about this child such as limitations, special diet, etc:

_____

PHYSICIAN STATEMENT: This child has been examined by me and found to be free of contagious disease and is physically able to participate in the program of Bowen Road Day School

_____ _____

Physician's Signature Date

_____ _____

Physician's Address Physician's Phone #

I certify that my child is enrolled in a regular medical program and has been examined by a physician within the last 12 mos.

_____ _____

Parent Signature Date

517 S Bowen Road Arlington, Texas 76013 (817)275-1291 FAX (817)548-0002