



British Private Prep Schools

Health Requirement Form

Fax to: 281-394-7781 CSW
 281-394-5803 FT
 281-828-2002 CE

Name of child: _____ Date of birth: _____

Immunization	Date/dose 1	Date/dose 2	Date/dose 3	Date/dose 4	Date of booster
Hep B					
DTP/DTaP/DT					
Polio IPV or OPV					
Hib-CV					
MMR					
Hep A					
PCV Pneumococcal					
Varicella See below					

Varicella (chickenpox) vaccine is not required if your child has had the chickenpox disease. If your child has had chickenpox, please complete the statement. My child has had varicella disease on or about (date) _____ and does not need the varicella vaccine.

Parent Signature _____ Date _____
 Health Care Professional's Signature _____ Date _____

Hearing and Vision Test Results listed below:

Vision	R/20 _____	L/20 _____	Pass	Fail
Signature _____ Date _____				
Hearing	1000Hz	2000Hz	4000Hz	
Right				Pass Fail
Left				Pass Fail
Signature _____ Date _____				

Signature or stamp and name of health care professional filling out the above information.

X _____ Print Name _____

Doctor's statement: I have examined the above named child within the past year and find that she/he is physically able to take part in a preschool program.

Physician's Signature _____ Date _____