

# FIRST UNITED METHODIST CHURCH DAY SCHOOL MEDICAL INFORMATION FORM

801 West Avenue B  
Garland, Texas 75040  
972-494-3096

TO BE COMPLETED BY PHYSICIAN'S OFFICE: The following immunizations are required by the State Department of Human Services. If any of these immunizations are not given at the required time, please explain why not and when it was given. When enrolling in advance for the school year beginning in September, the completed medical form must be in our office before the first day of school. When enrolling any other time during the year, the medical form must be in our office prior to the child's attendance in class.

Name of Child: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Age ► Vaccine ▼	Birth	1 mos	2 mos	4 mos	6 mos	12 mos	15 mos	18 mos	19-23 mos	2-3 Yrs	4-5 Yrs
Hepatitis B											
Rotavirus											
Diphtheria, Tetanus, Pertussis											
Haemophilus influenza type b											
Pneumococcal											
Inactivated Poliovirus											
Influenza											
Measels, Mumps, Rubella											
Varicella											
Hepatitis A											
Meningococcal											

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

\_\_\_\_\_  
Parent's signature \_\_\_\_\_  
Date

I am excluding my child from the immunization requirements for reasons of conscience, including a religious belief. I have attached an official notarized affidavit form developed and issued by the Department of State Health Services. I understand this affidavit is valid for 2 years.

## MEDICAL INFORMATION

Please check only one option:

1.  HEALTH CARE PROFESSIONAL STATEMENT: I have examined the above named child within the past year and find that he/she is able to take part in this program.  

\_\_\_\_\_
\_\_\_\_\_

Health Care Provider Signature Date
2.  A signed and dated copy of a health care professional's statement is attached.
3.  Medical diagnosis and treatment conflict with the tenets and practices of a recognized religious organization, which I adhere to or am a member of; I have attached a signed and dated affidavit stating this.
4.  My child has been examined within the past year by a health care professional and is able to participate in this program. Within 12 months of admission, I will obtain a health care professional's signed statement and will submit it to this program.

\_\_\_\_\_
\_\_\_\_\_

Family Physician Physician's Telephone
  
\_\_\_\_\_  
Physician's Address