Taylor ISD Child Development Center

Physician Signature Form

Last Name: ______________________ First: ______________________ MI: _____

Date of Birth: ______________________ Gender: ☐ M ☐ F
(mm/dd/yy)

Child's Doctor:
Name: ______________________
Address: ______________________
Phone: ______________________

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(This section to be completed by physician)

Physical Examination:

I certify that ______________________________ is in good health and physically able to take part in the Preschool program.
(name of child)

List any health conditions the school should be informed of (i.e., allergies, dietary restrictions, vision or hearing

difficulties, seizures, etc.): ____

______________________________ ______________________
Physician's Signature (required) **Date**

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Immunizations: *** ATTACH YOUR CHILD'S CURRENT IMMUNIZATION RECORD ***

☐ **Check here if your child is on a delayed or alternate immunization schedule** *(Affidavit required)*
If so, please contact the preschool director.

The following immunizations are required:

Immunization	# of Doses required
DTP/DTaP/DT/Td	5
MMR	2
OPV/IPV	4
Hep B	3

Immunization	# of Doses required
Hep A	2
Hib	4*
Varicella	1
Pneumoccocal	4

**Certain manufacturers only require 3 rounds. Consult your pediatrician for verification.*