## PINES PRESBYTERIAN PRESCHOOL 12751 KIMBERLEY HOUSTON, TX 77024 713

713-467-9358

Physician's signature or stamp

Date

(See reverse side.)

## \*\*\*HEALTH RECORD\*\*\*

HOME WORK OR CELL  AUTHORIZATION FOR EMERGENCY MEDICAL ATTENTION:  In the event that I cannot be reached to make arrangements for emergency medical attention, I authorize the director or person in charge child to:  Name of Licensed Physician Address Telephon  Or to (name of hospital or clinic) Address Telephon  I give my consent for necessary emergency treatment when my child is in the care of this physician and/or hospital/clinic.  Signature— Parent or Legal Guardian  IMMUNIZATION RECORD Month / day / year  IMMUNIZATIONS 1 2 3 4 5  DtaP  IPV  HIB  Hep B  MMR  Hep A  Pneumococcus  TB				200	consists on					
Street  MOTHER'S NAME:  TELEPHONE: HOME  WORK OR CELL  FATHER'S NAME:  TELEPHONE: HOME  WORK OR CELL  AUTHORIZATION FOR EMERGENCY MEDICAL ATTENTION:  In the event that I cannot be reached to make arrangements for emergency medical attention, I authorize the director or person in charge child to:  Name of Licensed Physician  Address  Telephon  Or to (name of hospital or clinic)  Address  Telephon  I give my consent for necessary emergency treatment when my child is in the care of this physician and/or hospital/clinic.  Signature— Parent or Legal Guardian  IMMUNIZATION RECORD Month / day / year  IMMUNIZATIONS  1 2 3 4 5  DtaP  IPV  HIB  Varicella vaccine  Hep B  MMMR  Hep A  Pneumococcus  TELEPHONE: HOME  WORK OR CELL HOME WORK OR CELL WORK OR CELL HOME	y / Year	Month / I	BIRTHDATE:	F.	SEX: M			Last	First	CHILD'S NAME: -
MOTHER'S NAME:  TELEPHONE: HOME WORK OR CELL  AUTHORIZATION FOR EMERGENCY MEDICAL ATTENTION: In the event that I cannot be reached to make arrangements for emergency medical attention, I authorize the director or person in charge child to:  Name of Licensed Physician Address Telephon  Or to (name of hospital or clinic) Address Telephon  I give my consent for necessary emergency treatment when my child is in the care of this physician and/or hospital/clinic.  Signature— Parent or Legal Guardian  IMMUNIZATION RECORD Month / day / year  IMMUNIZATIONS 1 2 3 4 5  DtaP  IPV  HIB  Waricella vaccine Hep B  MMR  Hep A  Pneumococcus TB		Zin	and the second s		City				Stroot .	ADDRESS:
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Signature			or hospital/clinic	sician and/	care of this phys	v child is in the	t when m	sency treatment	or nacessary american	I give my consent
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Month / day / year	Date			Suardian	arant ar Lagal C	Cinnelum D				
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HIB Varicella vaccine Hep B  MMR Hep A  Pneumococcus TB	6		5		RECORD	MUNIZATION F Month / day /		2	1	IMMUNIZATIONS
Hep B  MMR  Hep A  Pneumococcus  TB	6		5		RECORD	MUNIZATION F Month / day /		2	1	
MMR Hep A Pneumococcus TB	6		5	4	RECORD	MUNIZATION F Month / day /		2	1	DtaP
Hep A Pneumococcus TB	6	ccine		4	RECORD	MUNIZATION F Month / day /		2	1	DtaP IPV
Pneumococcus TB	6	cine		4	RECORD	MUNIZATION F Month / day /		2	1	DtaP IPV HIB
тв	6	ccine		4	RECORD	MUNIZATION F Month / day /		2	1	DtaP IPV HIB Hep B
TB .	6	ccine		4	RECORD	MUNIZATION F Month / day /		2	1	DtaP IPV HIB Hep B
	6	ccine		4	RECORD	MUNIZATION F Month / day /		2	1	DtaP IPV HIB Hep B MMR
Influenza vaccine	6	ccine		4	RECORD	MUNIZATION F Month / day /			1	DtaP IPV HIB Hep B MMR Hep A Pneumococcus
	6	ccine		4	RECORD	MUNIZATION F Month / day /			1	DtaP IPV HIB Hep B MMR Hep A Pneumococcus TB

Child's Name ———			
	SPECIAL SENSES SCREENING RECOR	RD (By physician/screener)	
√isual acuity and hearin noted on the first screen	g sensitivity screening are required for 4-year olds en ning. Speech screening is optional (not required.)	rolled in preschool. Rescreening is only requ	iired if an abnormality was
HEARING SCREENIN	NG:	VISION SCREENING:	
at 25dB R	L	DISTANCE ACUITY: R-20/	L-20/
500 Hz	PASS		
1000 Hz	FAIL—	PASS	
2000 Hz	RESCREEN	FAILRESCREEN	
4000 Hz			
	Date		Date
Physician's signature		Signature	
IMITED ACTIVITIES (I	List activities in which child should not participate):		
MEDICATION PRESCR	RIBED ON A REGULAR BASIS (Must be in original co		
SPECIAL DIET:		•	
SUGGESTED REFERR	XALS:		
	tor's statement: I have examined the above-named on the program.	child within the past year and find that he/she	is physically able to take
Physician's si	gnature (MUST SIGN BOTH SIDES)	Date	