PRESTON HOLLOW PRESBYTERIAN SCHOOL AND PRESCHOOL
9800 Preston Road
Dallas, Texas 75230
Fax to: 214-368-2255
Email to: kburns@phps.org

PHYSICIAN'S STATEMENT

Date_____

In order to comply with requirements of the State of Texas, it is necessary that this record be completed and on file prior to the first day of class at Preston Hollow Presbyterian School. Please submit this to your examining physician and forward to us before school starts.

NAME_____**DATE OF BIRTH**_____

ADDRESS_____**EXAMINATION DATE**_____

SCHEDULE OF IMMUNIZATIONS: (List Dates)

DPT 1._____2._____3._____4._____5._____6._____

POLIO 1._____2._____3._____4._____5._____6._____

MMR 1._____2._____ **VARICELLA** 1._____

HEPA 1._____2._____ **HIB VACCINE** 1._____2._____

PCV7 1._____2._____ 3._____4._____

3._____4._____ **HEPATITIS B** 1._____2._____

TB 1._____ 3._____

VISION:
Without glasses

R-Eye	**20/**
L-Eye	**20/**

VISION:
With glasses

R-Eye	**20/**
L-Eye	**20/**

HEARING:

Hz	**1000**	**2000**	**4000**
R-Ear			
L-Ear			

Physician's Statement: I have examined the above named child within the past year and find that he/she is physically able to take part in this school program.

***Physician's Signature**_____**Phone Number**_____

Address_____

***PLEASE NOTE: The Physician's signature must be a signature or signature stamp only. This form must be submitted to the school office prior to the first day of school.**