It is required by the State of Texas and Preston Hollow Presbyterian School for this record be submitted and on file in the school office. All students must have this form completed by their doctor and returned to the school office no later than August 1st. **

This form must be submitted to the school office prior to the first day of school.

PHYSICIAN'S STATEMENT

CHILD'S NAME_____ DATE OF BIRTH_____

ADDRESS_____

EXAMINATION DATE_____

SCHEDULE OF IMMUNIZATIONS: (Please List Dates)

DPT 1._____ 2._____ 3._____ 4._____ 5._____ 6._____

POLIO 1._____ 2._____ 3._____4 ._____ 5._____ 6._____

MMR 1._____ 2._____ VARICELLA 1._____

HEPA 1._____ 2._____ PCV7 1._____ 2._____ 3._____ 4._____

HIB VACCINE 1._____ 2._____ 3._____ 4._____

HEPATITIS B 1._____ 2._____3._____ TB 1._____

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 12 months and find that he/she is physically able to take part in this school program.

Physician's Signature* _____ Phone Number_____

Address_____

* The Physician's signature must be a signature or signature stamp only.

** An exemption from immunizations for medical reasons will require a written and signed statement from a board certified physician. An exemption from immunizations for reason of conscience will not be accepted.

*** Please return this form to the school office, fax to 214.368.2255 or email kmachaj@phps.org by August 1st***