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## Physician's Statement

*Please complete entire Enrollment form, do not leave blanks. PRINT CLEARLY!*

Name of Child _____	Date of Birth _____
I have examined the above child within the past year and find that he/she is able to take part in the preschool program.	
Health Care Professional Name _____	
Address _____ City _____ State _____ Zip _____	
Health Care Professional Signature _____ Date _____	

Vaccine Information	Birth	1 mos	2 mos	4 mos	6 mos	12 mos	15 mos	18 mos	19-23 mo	2-3 yrs	4-6 yrs
Hepatitis B											
Rotavirus											
Diphtheria, Tetanus, Pertussis											
Haemophilus Influenzae type B											
Pneumococccal											
Inactivated Poliovirus											
Influenza											
Measles, Mumps, Rubella											
Varicella											
Hepatitis A											
Meningocccal											

<b>Physician or Public Health Personnel Verification</b> Signature or Stamp of a physician or public health personnel verifying immunization information above. Signature _____ Date _____
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<b>Varicella</b> (chickenpox) 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 (chickenpox) on or about (date) _____ and does not need varicella vaccine. Parent Signature _____ Date _____
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<b>Requirements for Exclusion</b> <input type="checkbox"/> I have attached a signed and dated affidavit stating that I decline immunizations for reason of conscience, including religious belief, on the form described by Section 161.0041 Health and Safety Code submitted no later than the 90th day after the affidavit is notarized. <input type="checkbox"/> I have attached a signed and dated affidavit stating that the vision or hearing screening conflicts with the tenets or practices of a church or religious denomination that I am an adherent or member of. Parent Signature _____ Date _____
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