ST. LAURENCE WCP WEEKDAY CHILDREN'S PROGRAM

# St. Laurence Catholic Parish
# Weekday Children's Program

## IMMUNIZATION RECORD AND PHYSICAN STATEMENT

*I authorize the release of the following information in regard to my child's health.*
*Parent Signature*_____ *date*_____

**Child's Name** **Date of Birth**

| Vaccine | Date 1st dose | Date 2nd dose | Date 3rd dose | Date 4th dose | Date 5th dose |
|---|---|---|---|---|---|
| **Polio** | / / | / / | / / | / / | / / |
| **DTP/ DtaP** | / / | / / | / / | / / | / / |
| **Hib** | / / | / / | / / | / / | |
| **Hepatitis B** | / / | / / | / / | | |
| **MMR** | / / | / / | | | |
| **Varicella** | / / | / / | | | |
| **Hep A** | / / | / / | | | |
| **PCV7** | / / | / / | / / | / / | |

**TB Test Date** **Results**

**State Law requires for 4 year olds**
**Hearing Screening Date** **Results**

**Vision Screening Date** **Results**

**Attach a copy of current shot record. Doctor signature is required below.**

**PHYSICIAN STATEMENT**

_____ **was examined and is able to participate in early childhood program activities.**
Child's name

_____ _____
**physician's signature (required)** date

Physician's name_____

Address_____

naeyc Accredited

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