



Bright Beginnings Preschool

Adult TB Test <input type="checkbox"/> ppd <input type="checkbox"/> X-ray	Date Tested: _____ Result attached: _____
Participating Parent's Name: _____	

PHYSICIAN'S REPORT (TO BE COMPLETED BY PHYSICIAN)

CHILD'S FIRST NAME	LAST NAME	SEX	BIRTHDAY (Month/Day/Year)
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IMMUNIZATION RECORD: (Please fill out)

VACCINE	Date Each Dose Was Given - Month/Day/Year				
	1st	2nd	3rd	4th	5th
Polio (OPV or IPV)	/ /	/ /	/ /		
DTP/DTaP/DT/Td(Circle)	/ /	/ /	/ /	/ /	
Final Dose must be given after the first birthday MMR (measle, mumps, rubella)	/ /	/ /			
Final Dose must be given after the first birthday Hib Meningitis	/ /	/ /	/ /	/ /	
Hepatitis B	/ /	/ /	/ /		
Varicella (Chickenpox)	/ /				
Exemption: If a child is to be exempted for medical reasons, a doctor's written statement is required; the statement must include which immunization(s) is to be exempted and the specific nature and probable duration of the medical condition.					
Required Shots verified and up-to-date Physician's Signature (or Physician Assistant/Nurse Practitioner)			Physician's Address Stamp		
Date of Exam	Date Form Completed		Name		
			Address		
			Phone		

Remarks: (Office Use ONLY)