**The Apple Tree School**
**17127 Red Oak Dr.**
**Houston, TX 77090**
**Phone: 281-444-6707**
**Fax: 281-444-8884**
**theappletreeschool@aol.com**

# Health Requirements & Immunization Record 2020 - 2021

Child's Name:_________________________________________ D.O.B.: ______________________

| Immunizations | Date - 1st Dose | Date - 2nd Dose | Date - 3rd Dose | Date -1st Booster | Date -2nd Booster |
|---|---|---|---|---|---|
| DPT/Td | | | | | |
| Polio | | | | | |
| Hib-CV | | | | | |
| Measles: Vacc. | | | | | |
| Mumps: Vacc. | | | | | |
| Rubella: Vacc. | | | | | |

**NOTE: You may submit a machine copy of an immunization record signed or stamped by a physician or health personnel.**

**Physician's Verification Must Be Submitted**

**Pneumococcal Conjugate Date-1st Dose** **Date-2nd Dose** **Date-3rd Dose**

**Tuberculosis Test:** To be completed if recommended for the area by the Texas Department of Health. (Staff will inform you of these requirements)

**Tuberculosis Test Results**

☐ **Positive** ☐ **Negative** **Date:**______________________

______________________ Signature (or stamp)-Physician or health Professional ______ Date

______________________ Signature - Staff making handwritten Copy of Record ______ Date

**ADMISSION REQUIREMENTS:** One of the following must be presented when your pre-school-age child is admitted to Apple Tree School or within one week of admission. Check to indicate the option you select.

☐ Doctor'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 the program at The Apple Tree School.

______________________________________
Physician's Signature Date

☐ A copy of the medical screening from the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program IF no referral for further diagnosis and treatment is indicated.

☐ A form or written statement from a health service or clinic

**IF YOU DO NOT HAVE ANY OF THE ABOVE:**

☐ Parent's Statement: My child has been examined within the past year by a licensed physician and is able to participate in the program at The Apple Tree School. I will obtain a physician's statement, a copy of the medical screening form from the EPSDT Program, or a form or statement from a health service or clinic and will submit it to The Apple Tree School within 5 days of enrollment.

______________________________________
Name and Address of Physician OR Address of EPSDT Screening Site

☐ My child has an appointment for a physical examination. I will submit the physician's statement, EPSDT form, or health service or clinic form to The Apple Tree School following the examination.

______________________________________
Date of Appointment / Name and Address of Physician OR Address of EPSDT Screening Site

______________________ Signature - Parent or Legal Guardian ______ Date

NOTE: If medical diagnosis and treatment and/or immunization and TB testing conflict with your religious beliefs, you must sign an affidavit to that effect and attach it to this form. If immunization and/or TB testing would be injurious to your child or family you must obtain a certificate (signed by a physician) to that effect and attach it to this form.