

**COLONIAL HILLS UNITED METHODIST SCHOOL
REQUIRED ADMISSION INFORMATION**

Child's Name: _____ Birth Date: _____
 Child's Address: _____
 Parent's Name: _____ Phone: _____

Immunization Record:

I have provided the school with a copy of my child's most current immunization record.

Admission Requirement: Please check only one option:

1. **HEALTH-CARE PROFESSIONAL'S STATEMENT:** I have examined the above named child within the past year and find that he/she is able to take part in school.

_____ Date _____
 Health Care Professional's Signature

2. **A signed and dated copy of a health care professional's statement is attached.**

3. A medical diagnosis and treatment conflict with the tenets and practices of a recognized religious organization, which I adhere to or am a member of; I have attached a signed and dated affidavit stating this.

4. My child has been examined within the past year by a health care professional and is able to participate in school. Within 12 months of admission, I will obtain a health care professional's signed statement and will submit it to the school.

The name and address of health care professional who saw my child is:

_____ Child's name: _____

_____ Date _____
 Signature – Parent or Legal Guardian

VISION	R 20/ _____	L 20/ _____		<input type="checkbox"/> Pass <input type="checkbox"/> Fail
Signature _____	Date _____			
HEARING	1000 Hz	2000 Hz	4000 Hz	
R				<input type="checkbox"/> Pass <input type="checkbox"/> Fail
L				
Signature _____		Date _____		

AUTHORIZATION FOR EMERGENCY MEDICAL ATTENTION:

In the event I cannot be reached to make arrangements for emergency medical care, I authorize the person in charge to take my child to:

Name of Physician: _____ Phone: _____

Name of Emergency Medical Care Facility: _____ Phone: _____

I give consent for the facility to secure any and all _____
 necessary emergency medical care for my child. Signature-Parent or Legal Guardian

(over)

ADMISSION INFORMATION

HEALTH REQUIREMENTS

Name of Child:

Date of Birth:

Age Vaccine ▼	Birth	1 mos	2 mos	4 mos	6 mos	12 mos	15 mos	18 mos	19-23 Mos	2-3 Yrs	4-6 Yrs
Hepatitis B											
Rotavirus											
Diphtheria, Tetanus, Pertussis											
Haemophilus influenzae type b											
Pneumococcal											
Inactivated Poliovirus											
Influenza											
Measles, Mumps, Rubella											
Varicella											
Hepatitis A											
Meningococcal											

TB TEST (if required)

Positive

Negative

Date:

Signature or stamp of a physician or public health
personnel verifying immunization information above.

Signature

Date

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 disease (chickenpox) on or about (date) _____ and does not need varicella vaccine.

Parent's signature

Date

I am excluding my child from the immunization requirements for reasons of conscience, including a religious belief. I have attached an official notarized affidavit form developed and issued by the Department of State Health Services. I understand this affidavit is valid for 2 years.

For additional information regarding immunizations contact the Department of State Health Services at
www.dshs.state.tx.us/immunize/public.shtm

Signature – Parent or Legal Guardian

Date