



Student Name: _____
Enrollment Year 2024-2025

HEALTH INFORMATION FORM

(ALSO PLEASE ATTACH CURRENT IMMUNIZATION RECORD)
DUE BY WEDNESDAY JUNE 12, 2024

Texas Dept of Family and Protective Services

Form 2935

SCHOOL AGE CHILDREN:
 My child attends the following school:

Day School for Little People 3700 N. HWY 146 Baytown, TX 77520 **281-422-3449**
 Name of School and Address School Ph.#

CHECK ALL THAT APPLY:

<input type="checkbox"/> His / her immunization record is on file at the school and all required immunizations and/or tuberculosis test are current. Vision and Hearing screening records are also on file.	My child has permission to: <input type="checkbox"/> be released to the care of his/her sibling(s) under 18 years old.
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IMMUNIZATION RECORD:

I have provided the childcare operation with a copy of my child's most current immunization record, SIGNED/INITIALED BY PHYSICIAN OR RUBBER STAMPED BY DOCTOR'S OFFICE.

ADMISSION REQUIREMENT: If your child does not attend pre-kindergarten or school away from the child-care operation, one of the following must be presented when your child is admitted to the child-care operation or within one week of admission.
 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 the day care program.

_____ **Health Care Professional's Signature** _____ **Date**

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

3. 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 the day care program. Within 12 months of admission, I will obtain a health care professional's signed statement and will submit it to the child-care operation.

Name and address of health care professional:

_____ **Signature - Parent/Guardian or Legal Guardian** _____ **Date**

VISION	R 20/ _____	L 20/ _____	<input type="checkbox"/> PASS <input type="checkbox"/> FAIL	
SIGNATURE _____		DATE _____		
HEARING	1000 Hz	2000 Hz	4000 Hz	<input type="checkbox"/> PASS <input type="checkbox"/> FAIL
R				
L				
SIGNATURE _____		DATE _____		

***Hearing and Vision is required for all four year old students. We will have testing at our school in the fall semester. If your child has already been tested, please have your physician fill out the box above completely.**

_____ **Signature - Parent/Guardian or Legal Guardian.** _____ **Date**