

# Heritage Children's Learning Center

6840 S. Mason # 200 Katy, Tx. 77450  
 PHONE 281-398-1188 FAX 281 398-2887

CHILD'S NAME \_\_\_\_\_ DOB \_\_\_\_\_

DOCTOR'S NAME \_\_\_\_\_ PHONE: \_\_\_\_\_

HOSPITAL NAME \_\_\_\_\_ PHONE: \_\_\_\_\_

I give my consent for necessary emergency treatment when my child is in care at this institution.

**MEDICAL HISTORY** CHECK ANY OF THE FOLLOWING YOUR CHILD HAS HAD

( ) Asthma	( ) Hay Fever	( ) Ear Infections
( ) Chicken Pox	( ) Head Injury	( ) Ear Tubes
( ) Convulsions	( ) Measles	( ) Strep Throat

KNOWN ALLERGIES \_\_\_\_\_

KNOWN DRUGS ALLERGIES \_\_\_\_\_

**IMMUNIZATION RECORD**

	1ST	2ND	3RD	BOOSTER	BOOSTER
<b>POLIO</b>					
<b>DPT</b>					
<b>HIB</b>					
<b>MEASLES</b>					
<b>VARICELA</b>					
<b>PCV</b>					
<b>HEP. B</b>					
<b>HEP. A</b>					

**ADMISSION REQUIREMENT:** One of the following must be presented when your pre-school-age child is admitted to the day care facility or within one week of admission. Indicate your option:

- Doctor's Statement:** I have examined the above-name child within the past year and she/he is physically able to attend to a day care program. \_\_\_\_\_ Physician's Signature      \_\_\_\_\_ Date
- A form or written statement for 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 day care program.

\_\_\_\_\_  
SIGNATURE PARENT OR LEGAL GUARDIAN

\_\_\_\_\_  
DATE