Texas Preschool Health Statement Form

Child's Full Name: _____

Date of Birth: _____

Parent/Guardian Name: _____

Date: _____

Health-Care Professional's Statement

I have examined the above-named child within the past year and find that:

☐ The child is able to take part in the preschool program.

☐ The child is free of contagious or infectious diseases.

☐ The child is current on all required immunizations.

Physician's Name: _____

Phone Number: _____

Clinic Address: _____

Signature of Health-Care Professional: _____

Date: _____

Immunization Record (Attach a copy of the child's current immunization record, signed or stamped by the healthcare provider.)

Vision and Hearing Screening (Required for children 4 years and older)

Vision Screening:
- Right Eye: 20/_____ Left Eye: 20/_____

Hearing Screening:
- Right Ear: _____ Left Ear: _____

Signature of Health-Care Professional: _____

Date: _____

Allergies

Does your child have any known allergies?
☐ No

☐ Yes (If yes, please describe below)

Allergy Description:
_____

Reaction: _____

Treatment or Medication Required:
_____

If so, please include an allergy emergency care plan from the doctor

Medication

Please list any medications your child is currently taking (including those taken at home):

Medication Name(s):
_____

_____

_____

Reason(s) for Medication:
_____

Important Note: This preschool does not administer medication. Parents/guardians are responsible for any medication administration required during school hours.

Parent/Guardian Acknowledgment

I certify that the information provided is accurate and complete to the best of my knowledge.

Signature of Parent/Guardian:_____

Date: _____