HIGHLAND PARK UNITED METHODIST CHURCH
CHILD DEVELOPMENT PROGRAM
MEDICAL INFORMATION FORM

IMMUNIZATION RECORD

Name of Child: ___________________________________ **Date of Birth: _______________________**

IMMUNIZATIONS	**Date/dose 1**	**Date/dose 2**	**Date/dose 3**	**Date/dose 4**	**Date/booster**
DTP/DTaP/DT					
Polio IPV or OPV					
Measles/Mumps/Rubella					
Pneumococcal					
Hib					
Hepatitis A					
Hepatitis B					
TB Test (if required**)**	☐Positive	☐Negative	Date:		
Varicella (see below)					

____________________________________ ______________________________
Signature of Health Care Professional 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 require varicella vaccine.

______________________________ ____________________
Parent's Signature Date

☐ 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.

☐ I am claiming an Exemption from Immunizations for Reasons of Conscience. I have attached the required signed and dated affidavit from the State of Texas.

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AUTOHORIZATION 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 Address Phone

__________________________________ __________________________ ___________________________
Name of Emergency Medical Care Facility Address Phone

I give consent for the facility to secure any and all emergency medical care for my child.

____________________________________ ________________________
Parent's Signature **Date**