

**HIGHLAND PARK UNITED METHODIST CHURCH
DAY SCHOOL
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)	<input type="checkbox"/> Positive	<input type="checkbox"/> 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.

Parent Signature

Date