MEDICAL RELEASE FORM

Child's Name ____ Current Age _______ DOB _____________

<u>*****MUST BE COMPLETED BY YOUR PHYSICIAN*****</u>

A current immunization record showing that the child is immunized against certain vaccine-preventable diseases as required by the Texas Department of State Services must accompany this form. A new/updated immunization record must be submitted after the child's yearly exam.

TB Results: Positive __________ Negative __________ Date __________ N/A ☐
(Tuberculosis test to be completed if recommended by the Texas Department of Health.)
Physician's verification must be submitted if the child has had measles, mumps, or Varicella (Chickenpox).

<u>**PHYSICIAN'S VERIFICATION OF MEASLES, MUMPS, AND/OR VARICELLA (CHICKENPOX) ILLNESS:**</u>
This is to verify that this child had:

- ☐ Measles Approximate Date of Illness ________________
- ☐ Mumps Approximate Date of Illness _______________
- ☐ Varicella (chickenpox) Approximate Date of Illness ______________

and does not need the vaccine.

Physician's Signature ____

Each child entering St. Stephen Presbyterian Day School is required to present the following statement certifying that the child has been examined by a physician within the past year, immunizations are up-to-date, and the child is physically able to participate in the school program.

<u>**PHYSICIAN'S STATEMENT:**</u>

I have examined the above child within the past year and find that he/she is physically and mentally able to take part in the St. Stephen Presbyterian Day School program.

____
Physician's Signature (Mandatory) Address

____
Physician's Name (Please Print) Phone # Date

Physician's License Number ________________________________