

Student's Health Record

All students must have a health examination for the 2017–2018 school year. **A physician's signature is required.**

Child's Name _____ Sex Male / Female Birthdate _____

Physician _____ Phone _____

Address _____ City _____ Zip Code _____

Dentist _____ Phone _____

Address _____ City _____ Zip Code _____

Known Allergies _____

Current Medications _____

Any Required Special Diet _____

Any Chronic Health Conditions _____

Please describe other health concerns/problems that we should know about while your child is in our care.

Current Immunization Form must also be completed and on file before the first day of school.

Health Care Provider (Please complete this section.)

Physical Exam: Normal / Abnormal

Significant Health Concerns: Seizures / Asthma / Diabetes / Allergies / Heart or Respiratory Conditions

Physical Disabilities / Other: _____

Any other concerns _____

Information and instructions on any health issues _____

Next scheduled exam date _____

Physician's Signature _____ Date _____

Medical Consent

I hereby give my consent to Community Preschool to seek emergency medical attention for my child. I understand that I accept any expenses incurred.

In the event of an emergency, Community Preschool and its representatives will activate the emergency medical system by calling 911, and then make reasonable efforts to contact a parent or guardian at the numbers listed below.

Date _____

Parent's Signature _____

Parent's Home Phone _____

Parent's Cell Phone _____

Parent's Authorization to Release Student for Treatment

Signature _____ Date _____



Certificate of Immunization for Electronic Records

You may type in the boxes and print using the free Adobe Acrobat Reader.
To save the completed form, you must have the full Acrobat program or Reader version 7 or greater.

COLORADO LAW REQUIRES THAT THIS FORM BE COMPLETED FOR EACH STUDENT ATTENDING COLORADO SCHOOLS

Name _____ Date of Birth _____

Parent/Guardian _____

COLORADO DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT—CERTIFICATE OF IMMUNIZATION

Vaccine		Enter the month, day and year each immunization was given						Titer Date
Hep B	Hepatitis B							
DTaP	Diphtheria, Tetanus, Pertussis (pediatric)							
DT	Diphtheria, Tetanus (pediatric)							
Tdap	Tetanus, Diphtheria, Pertussis							
Td	Tetanus, Diphtheria							
Hib	<i>Haemophilus influenzae</i> type b							
IPV/OPV	Polio							
PCV	Pneumococcal Conjugate							
MMR	Measles, Mumps, Rubella							
Measles	Measles							
Mumps	Mumps							
Rubella	Rubella							
Varicella	Chickenpox					Provider Documentation Date of Disease	Positive Screen Date	
Vaccines recorded below this line are recommended. Recording of dates is encouraged.								
HPV	Human Papillomavirus							
Rota	Rotavirus							
MCV4/MPSV 4	Meningococcal							
Hep A	Hepatitis A							
Flu	Influenza							
Other								

THIS SECTION CAN BE COMPLETED BY CHILD CARE/SCHOOL/HEALTH CARE PROVIDER

- A) Child Care Up to Date**
Up to date through 6 months of age for Colorado School Immunization Requirements
Update Signature _____ Date _____
- B) Child Care Up to Date**
Up to date through 18 months of age for Colorado School Immunization Requirements
Update Signature _____ Date _____
- C) Child Care/Pre-school/Pre-K***
Up to date for Child Care/Pre-School/Pre-K for Colorado School Immunization Requirements
Update Signature _____ Date _____
- D) Complete for K–5th Grade**
Up to date for K–5th Grade for Colorado School Immunization Requirements
Update Signature _____ Date _____

* If age 4 years and fulfills Requirements for Pre-School & Kindergarten, check BOTH Boxes C and D.

Name _____ Date of Birth _____

Parent/Guardian _____

**STATEMENT OF EXEMPTION TO IMMUNIZATION LAW
(DECLARACIÓN RESPECTO A LAS EXENCIONES DE LA LEY DE VACUNACIÓN)**

**IN THE EVENT OF AN OUTBREAK, EXEMPTED PERSONS MAY BE SUBJECT TO EXCLUSION FROM SCHOOL AND TO QUARANTINE.
SI SE PRESENTA UN BROTE DE LA ENFERMEDAD, ES POSIBLE QUE A LAS PERSONAS EXENTAS SE LES PONGA EN CUARENTENA O SE LES EXCLUYA DE LA ESCUELA.**

MEDICAL EXEMPTION: The physical condition of the above named person is such that immunization would endanger life or health or is medically contraindicated due to other medical conditions.

EXENCIÓN POR RAZONES MÉDICAS: El estado de salud de la persona arriba citada es tal que la vacunación significa un riesgo para su salud o incluso su vida; o bien, las vacunas están contraindicadas debido a otros problemas de salud.

Medical exemption to the following vaccine(s):

La exención por razones médicas aplica a la(s) siguiente(s) vacuna(s):

Hep B DTaP Tdap Hib IPV PCV MMR VAR

Signed (Firma) _____ Date (Fecha) _____
Physician (Médico)

RELIGIOUS EXEMPTION: Parent or guardian of the above named person or the person himself/herself is an adherent to a religious belief opposed to immunizations.

EXENCIÓN POR MOTIVOS RELIGIOSOS: El padre o tutor de la persona arriba citada, o la persona misma, pertenece a una religión que se opone a la inmunización.

Religious exemption to the following vaccine(s):

Exención por motivos religiosos de la(s) siguiente(s) vacuna(s):

Hep B DTaP Tdap Hib IPV PCV MMR VAR

Signed (Firma) _____ Date (Fecha) _____
Parent, guardian, emancipated student/consenting minor
(Padre, tutor, estudiante emancipado o consentimiento del menor)

PERSONAL EXEMPTION: Parent or guardian of the above named person or the person himself/herself is an adherent to a personal belief opposed to immunizations.

EXENCIÓN POR CREENCIAS PERSONALES: Las creencias personales del padre o tutor de la persona arriba citada, o la persona misma, se oponen a la inmunización.

Personal exemption to the following vaccine(s):

Exención por creencias personales de la(s) siguiente(s) vacuna(s):

Hep B DTaP Tdap Hib IPV PCV MMR VAR

Signed (Firma) _____ Date (Fecha) _____
Parent, guardian, emancipated student/consenting minor
(Padre, tutor, estudiante emancipado o consentimiento del menor)