PHYSICIAN'S STATEMENT

The following child plans to attend Sprouting Seeds School. We would appreciate you filling in and promptly returning the following information for our records.

NAME OF CHILD: ___________________________________ BIRTHDATE: _________________

IMMUNIZATION RECORD:

Diphtheria Pertussis Tetanus (DPT)

_______________ 2 months

_______________ 4 months

_______________ 6 months

_______________ 15-18 months

_______________ 4-6 years

Polio (OPV/IPV)

_______________ 2 months

_______________ 4 months

_______________ 6-18 months

_______________ 4-6 years

Measles, Mumps, Rubella (MMR)

_______________ 12-15 months

_______________ 4-6 years

Hepatitis B (HBV)

_______________ Birth

_______________ 2 months

_______________ 6-18 months

Haemophilus influenza b (Hib)

_______________ 2 months

_______________ 4 months

_______________ 6 months

_______________ 12-15 months

List known allergies and precautions:

List communicable diseases the child has had:

Name and indicate dosages for any regularly administered medications:

Is the child in good health and able to participate in supervised group activities?

________ YES

________ NO (Please provide instructions or recommendations for any existing limitations)

Physician's Signature: ____ Date: __________________

Address: ____

** Please return this form to the parent OR mail to:

Sprouting Seeds School
C/O Registrar
P.O. Box 1294
Battle Ground, WA 98604