PHYSICIAN'S STATEMENT

The following child plans to attend Columbia Kids Cooperative Preschool classes with his/her parent. We would appreciate your filling in and promptly returning the following information for our records.

NAME OF CHILD:_____ BIRTHDATE:_____

IMMUNIZATION RECORD:	DATES:	REQUIRED AGES
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
Columbia Kids Preschool
Attn: Preschool Representative
P.O. Box 1294
Battle Ground, WA 98604