Immunization and Health Statement

Forms may be emailed to EACY@AustinYMCA.org faxed to: 512-472-2164 or brought to main office: 55 N IH 35 78702

Child's Name: _____ Date of Birth:_____
Parent Name:_____Daycare Site: _____

Immunization Records:	The Texas Department of Public Safety requires us to have an up to date copy of your child's immunization record. Immunization record must be submitted to our EAC Y business office before care begins.

Please *initial* the statement applicable to you.

1._____I have provided Extend-A-Care YMCA with a copy of my child's most current immunization record and I understand that I am to provide Extend-A-Care YMCA with an updated copy of my child's immunizations each time he/she receives them.

2._____I am excluding my child from immunizations due to religious beliefs or reasons of conscience. I have provided Extend-A-Care YMCA with a signed affidavit as required by the State of Texas. For More information regarding immunization exemption please visit the Texas Department of State Health Services at www.dshs.state.tx.us/immunize.

Physician's Health Statement:	One of the following must be submitted to our business office before care begins. Physician statement is good for one calendar year.

Please check the item you're submitting.

1. ☐ **HEALTH-CARE PROFESSIONAL'S STATEMENT:** I have examined the above named child within the past year and find that he/she is able to take part in the child care program.

_____ _____
Health Care Professional's Signature Date

2. ☐ A signed and dated copy of a health care professional's statement is attached.

Vision & Hearing Screening (4 years and older only)	The Texas Health and Safety Code requires that children 4 years and older must be screened or have a professional examination for possible hearing and vision problems.

Please check the item you're submitting.

1. ☐ **HEALTH-CARE PROFESSIONAL'S STATEMENT** I have examined above named child and results are listed below.

Vision	R 20/_____	L 20/_____		☐ Pass ☐ Fail

_____ _____
Health Care Professional's Signature Date

Hearing	1000 Hz	2000 Hz	4000 Hz	☐ Pass ☐ Fail
R				
L				

_____ _____
Health Care Professional's Signature Date

2. ☐ A signed and dated copy of a health care professional's statement is attached.

_____ _____
Signature – Parent or Legal Guardian Date