*Please Return This Form To Your Child's Teacher Before or On Parent Orientation Night*

**UNITED CHURCH PRESCHOOL**
**CERTIFICATE OF IMMUNIZATION AND MEDICAL RELEASE**

*To be completed by physician:*

Child's Name: ________________________________ Sex: ______________
Address: ____________________________________ Birthdate: ___________

**IMMUNIZATION REQUIRED FOR SCHOOL ATTENDANCE** (full dates required)

| DtaP/DTP/DT/Td | | | | |
|---|---|---|---|---|
| Polio/OPV/IPV | | | | |
| Mumps | | | | |
| Measles | | | | |
| Rubella | | | | |
| MMR | | | | |
| Hib | | | | |
| Hepatitis B | | | | |
| Varicella/Varivax | | | | |
| T.B. Test Result | | | | |

**1.** Does this child have any physical, mental, or emotional handicap(s) that could affect his/her participation in the United Church Preschool, or that of his/her classmates? If so, please specify:

______________________________________________
______________________________________________
______________________________________________

2. Does this child take any medication on a daily basis? If so, please specify:

______________________________________________
______________________________________________
______________________________________________

3. Does this child have any allergies? If so, please specify:

______________________________________________
______________________________________________
______________________________________________

Physician Name: ______________________________ Phone: ________________

Address: ____________________________________________________

Signature of Physician: ___________________________ Date: ________________