CERTIFICATE OF GOOD HEALTH

Child's Name _____ Date of birth _____

IMMUNIZATIONS

Vaccine	Dates administered
• DPT/DT/Td	1._____2._____3._____4._____5._____ 6._____7._____8._____9._____10._____
• Haemophilus Influenza Type b	1._____2._____3._____4._____
• Polio PPV/IPV	1._____2._____3._____4._____5._____
• MMR	1._____2._____
• Varicella	1._____2._____ Chicken Pox_____
• Hepititis B	1._____2._____3._____

Other vaccines:_____
Health conditions:_____
Health Restrictions:_____
_____
_____

I agree that my child is in good health and is capable of fulfilling the activities offered while in care at Trinity Lutheran Early Childhood Center. If any complications arise, making it so that my child cannot fulfill an activity, I shall provide the center with a doctor's statement noting my child's limitations. The doctor's note shall state a date as to when my child can resume normal activity.

Parent's Signature_____Date_____

Updated:_____Parent's Signature_____

Updated:_____Parent's Signature_____

Updated:_____Parent's Signature_____