



Rainbow Station®
CERTIFICATE OF IMMUNIZATION

Student's Name: _____ **Date of Birth:** _____

| IMMUNIZATIONS | RECORD COMPLETE DATES (month, day, year) OF VACCINE DOES GIVEN | | | | |
|--|--|---|-------------------------------------|--------|---|
| Diphtheria, Tetanus, Pertussis (DTP, DTAP) | 1 | 2 | 3 | 1 | 1 |
| Poliomyelitis (OPV or IPV) | 1 | 2 | 3 | | |
| Haemophilus Influenza Type b (Hib conjugate Vaccine) | 1 | 2 | 3 | | |
| Measles, Mumps, Rubella (MMR vaccine) | 1 | 2 | Other(List type and date received): | | |
| Hepatitis A Vaccine | 1 | 2 | 3 | Other: | |
| Hepatitis B Vaccine (HBV) | 1 | 2 | 3 | 4 | |
| Varicella Vaccine | 1 | 2 | Other: | | |
| Rotavirus Vaccine | 1 | 2 | 3 | Other | |
| Pneumococcal | 1 | 2 | 3 | 4 | |

MEDICAL EXEMPTION: I certify that the administration of the vaccine(s) designated below would be detrimental to the student's health. The vaccine(s) is (are) specifically contraindicated because (please specify):

DTP/DtaP:[_]; OPV/IPV:[_]; Hib:[_]; MMR:[_]; Hepatitis A:[_]; Hepatitis B:[_]; Varicella:[_]; Rotavirus:[_]; Pneumococcal:[_];

This contradiction is permanent [_] or temporary [_] and expected to preclude immunization until: Date (M,D, Y): |_|_|_|_|

Signature of Physician or Health Department Official: _____ **Date (M,D, Y):** |_|_|_|_|

RELIGIOUS EXEMPTION: Policy allows a child an exemption from receiving immunizations required for a school attendance if the student of the student's parent/guardian submits an affidavit to the school's admitting official stating that the administration of immunizing agents conflicts with the student's religious tenets or practices. Any student entering school must submit this affidavit on a CERTIFICATE OF RELIGIOUS EXEMPTION, which may be obtained from any local health department or department of social services.

ADMISSION REQUIREMENT: If your child does not attend pre-kindergarten or school away from the child-care operation, one of the following must be presented when your child is admitted to the child-care operation

Please check only one option:

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 school program.

_____ Health Care Professional's Signature _____ Date _____

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

Student's Name: _____ Date of Birth: _____

| Required Screening Test | Explanation | Result | | |
|---|---|------------|-----------|-----------|
| Vision Screen (4 Yr. & above) | Distance visual acuity without correction | Right: 20/ | Left: 20/ | Both: 20/ |
| | Distance visual acuity with correction | Right: 20/ | Left: 20/ | Both: 20/ |
| Hearing Screen (4 Yr. & above) | Right: | Left: | | |
| Vision and hearing screenings are required by the Special Senses and Communication Disorders Act for all students in prekindergarten. | | | | |

Vision Screening:

Child to be prescreened? Yes: No:

Child to be prescreened? Yes: No:

Hearing:

Child to be prescreened? Yes: No:

Child to be prescreened? Yes: No:

| Condition | Yes | No | Comments if "Yes" |
|--|-----|----|-------------------|
| Allergies (food, insects, drugs, latex) | | | |
| Allergies (seasonal) | | | |
| Asthma or breathing problems | | | |
| Attention-Deficit/Hyperactivity Disorder | | | |
| Behavioral problems | | | |
| Bladder problems | | | |
| Bleeding problems | | | |
| Bowel problems | | | |
| Cerebral Palsy | | | |
| Cystic Fibrosis | | | |
| Dental problems | | | |
| Developmental problems | | | |
| Diabetes | | | |
| Head or spinal injury | | | |
| Hearing problems or deafness | | | |
| Heart problems | | | |
| Hospitalizations (when, why) | | | |
| Lead poisoning | | | |
| Muscular problems | | | |
| Seizures | | | |
| Sickle Cell Disease (not trait) | | | |
| Speech problems | | | |
| Surgery | | | |
| Vision problems | | | |
| Other: | | | |

List all prescription and over the counter medications your child takes regularly: _____

Describe any other important health-related information about your child (i.e., feeding tube, oxygen support, hearing aid, etc): _____

Name of your child's pediatrician or primary care provider: _____

Names of medical specialists or special clinics caring for your child: _____

Has your child ever seen a dentist? Yes: No: If yes, date of last appointment: _____

Check here if you want to discuss confidential information with the Get Well Place nurse or school authority: Yes: No:

Check here if you give permission for the Get Well Place nurse or other school authority to contact the examining physician to discuss any information contained on this form: Yes: No:

Signature – Parent or Legal Guardian

Date