Orchard Park Cooperative Preschool Health Certificate

(also available at www.opcoop.com)

Health History

Please **fill out** the vaccine information below *OR* **attach a copy** of your child's vaccine records.
Bottom portion to be completed by child's physician

Child's Name: _____ DOB:_____

State Required Immunizations:

1. Diphtheria 3 doses dates: _____ _____ _____

2. Polio 3 doses dates: _____ _____ _____

3. MMR (Measles, Mumps, Rubella vaccine) 1 dose date: _____

4. HIB (Haemophilus influenza type b) 3 doses dates: _____ _____ _____

If administered after 15 months of age, 1 dose date: _____

5. Hepatitis B 3 doses dates: _____ _____ _____

6. Tetanus-3 doses for children born on or after 01/01/05: _____ _____ _____

7. Pertussis-3 doses for children born on or after 01/01/05: _____ _____ _____

Does child have any physical or chronic condition (i.e., sight, hearing, allergy, etc.)?

_____

Varicella Vaccination:_____or Date of Chicken Pox_____

Provider Statement

_____has been examined by me and found physically
(Name of Child)
able to participate in a preschool program.

Health Care Provider: _____
(print)

Provider's Signature: _____Date: _____