MARY'S LITTLE LAMBS
Family Home Daycare
4811 Lilac Lane, Victoria, TX 77904 • (361) 576-0804 • maryslittlelambs.info

Well-Baby Statement

_____
Child's Name

Immunization Record

Please select one of the four options below…

Option 1

Immunizations	Date of Dose 1	Date of Dose 2	Date of Dose 3	Date of Dose 4	Date of Booster
Hepatitis B					
DTP/DTaP/DT					
Hib					
Polio IPV or OPV					
Measles					
Mumps					
Rubella					
Varicella (see below)					
Pneumococcal Conjugate Vaccine					
Hepatitis A					
TB Test (if required)	☐ Positive	☐ Negative	Date:		

I certify that to the best of my knowledge the immunization information provided above is correct.

Physician or Health Personnel's Printed Name _____ Physician or Health Personnel's Signature or Stamp _____ Date _____

Option 2

☐ A copy of my child's immunization record is attached and is signed and dated by a health care professional.

Option 3 (For School Age Children Only)

☐ My child's immunization record is on file at the school and all required immunizations and/or tuberculosis test are current; vision and hearing screening records are also on file.
My child attends school at: _____

School's Address _____ School's Phone Number _____

Option 4

☐ I am excluding my child from the immunization requirement for reasons of conscious, including a religious belief. I have attached an official notarized affidavit form developed and issued by the Department of State Health Services. I understand that this affidavit is valid for two years.

The varicella (chickenpox) vaccine is not required if your child has had the chickenpox disease. If your child has had chickenpox, please complete the this statement:
My child has varicella disease (chickenpox) on or about (date) _____ and does not need a varicella vaccine.

Parent/Legal Guardian's Printed Name _____ Parent/Legal Guardian's Signature _____ Date _____

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Hearing and Vision Screening

VISION	R 20/	R 20/	☐ PASS	☐ FAIL
Health Care Professional's Printed Signature			Date	

HEARING	1000hz	2000hz	4000hz	☐ PASS	☐ FAIL
Right					
Left					
Health Care Professional's Printed Signature				Date	

Health-Care Professional's Statement

Please select one of the three options below…

Option 1

☐ I have examined the above named child within the past year and find that he/she is physically able to take part in the daycare program.

Physician or Health Personnel's Printed Name _____ Physician or Health Personnel's Signature _____ Date _____

Option 2

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

Option 3

☐ Medical diagnosis and treatment conflict with the tenets and practices of a recognized religious organization, which I adhere to or am a member of; I have attached a signed and dated affidavit stating this.

I certify that the information provided above is correct to the best of my knowledge.
This document is signed in _____ County in the state of _____

Mother/Legal Guardian's Printed Name _____ Mother/Legal Guardian's Signature _____ Date _____

Father/Legal Guardian's Printed Name _____ Father/Legal Guardian's Signature _____ Date _____