234 N. Gohmert St./P.O. Box 706
Yorktown, Texas 78164
(Phone) 361-564-9444
(Fax) 361-564-9222

Physician's Statement

Name of Child _____ Date of Birth _____

I have examined the above child within the past year and find that he/she is in good physical health to attend your child care program.

Health Care Professional Name: _____

Address: _____ City _____ State ____ Zip _____

Health Care Professional Signature: _____ Date _____

Attached is a copy of the child's shot record.

Signature or Stamp of physician or public health personnel verifying immunization information.

Health Care Professional Signature: _____ Date _____

Complete ONLY if Applicable

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

Parent Signature _____ Date _____

Complete ONLY if Applicable

I am excluding my child from the immunization requirements for reasons of conscience, including a religious belief. I have attached an official notarized affidavit form developed and issued by the Department of State Health Services. I understand this affidavit is valid for 2 years.
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.

Parent Signature _____ Date _____