

Physician Signature Form

| Last Name: | | | First: | | MI: |
|--------------------|-------------------|-----------------------|------------------------------|--|-----|
| Date of Birth: | / | / | Gender: | M ? F | |
| | (mm | ı/dd/yyyy) | · | | |
| | Name: | | | | |
| Child's Doctor: | Address: | | | | |
| | Phone: | | | | |
| List any health co | (name of child) | 1: is in go | d of (i.e., allergies, dieta | y able to take part in the Presch ary restrictions, vision or hearing | |
| Physicia | n's Signature (re | equired) | | Date | _ |
| Che | ck here if you | | ed or alternate immu | T IMMUNIZATION REC | |
| | | | | | |

The following immunizations are required:

| Immunization | # of Doses required | Immunization | # of Doses required |
|----------------|---------------------|--------------|---------------------|
| DTP/DTaP/DT/Td | 5 | Нер А | 2 |
| MMR | 2 | Hib | 4* |
| OPV/IPV | 4 | Varicella | 1 |
| Нер В | 3 | Pneumoccocal | 4 |

^{*}Certain manufacturers only require 3 rounds. Consult your pediatrician for verification.