

ST. MARK CATHOLIC PRESCHOOL • ADMISSION REQUIREMENT FORM

Melanie Rutkoski, Director

ADMISSION REQUIREMENT: I understand that this form MUST be completed in its entirety and returned to the St. Mark Catholic Preschool office before my child's first day of enrollment and will be included in my child's records and kept in the office. J-800-2935 p.3-6.6

Child's Full Name _____ **Date of Birth** ____/____/____

HEALTH STATEMENT Complete only one of the three options.

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 preschool program.

Health Care Professional's Signature

Date

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

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.

SIGNATURE of PARENT or LEGAL GUARDIAN

DATE

VACCINE INFORMATION Attach a copy of the record or have a Health Care Professional complete the information below including Record Verification.

_____ I have attached a copy of my child's up to date shot record.

	Date/Dose 1	Date/Dose 2	Date/Dose 3	Date/Dose 4	Date/Booster	Date/Booster
Hepatitis B						
DtaP						
Polio						
MMR						
Hib						
Hepatitis A (2 doses required)						
Pneumococcal Conjugate						
Varicella (Chicken Pox)	Date of Vaccine:		Date of 2 nd Dose:		Date of Disease:	
TB Test (Dr.'s Option)	Positive:		Negative:		Date:	

← Record Verification

Health Care Professional's Signature/Stamp

Date

VARICELLA (CHICKENPOX)

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 disease (chickenpox) on or about _____ and does not need varicella vaccine. (DATE)

SIGNATURE of PARENT or LEGAL GUARDIAN

DATE

HEARING AND VISION SCREENING is required for children 4 years old.

Attach a copy of the record or have a Health Care Professional complete the information below including Record Verification.

_____ I have attached a copy of my child's Hearing and Vision Screening.

HEARING

25db	Right	Left
500 Hz		
1000Hz		
2000 Hz		
4000 Hz		

_____ Pass _____ Fail _____ Wears hearing aid

Vision Screening:

Distance acuity: R: 20/____ L: 20/____
 _____ Pass _____ Fail
 _____ Child wears glasses

Record Verification

Health Care Professional's Signature/Stamp

Date

ADDITIONAL INFORMATION REGARDING IMMUNIZATIONS

For additional information regarding immunizations, visit the Texas Department of State Health Services' website at www.dshs.state.tx.us/public.shtm.

GANG FREE ZONE

Under the Texas Penal Code, any area within 1,000 feet of a child care center is a gang-free zone, where criminal offenses related to organized criminal activity are subject to harsher penalties.

PRIVACY STATEMENT

DFPS values your privacy. For more information, read our Privacy and Security Policy online at <http://www.dfps.state.tx.us/policies/privacy.asp>.

SIGNATURES

SIGNATURE of PARENT or LEGAL GUARDIAN **DATE**

Melanie Rutkoski, Director / Valerie Cervantes Admin. Assistant **DATE**