

Memorial Lutheran School
5800 Westheimer
Houston, TX 77057
Phone - 713.782.4022 Fax - 713.782.1749

Health/Immunization Report

Child's name _____ Date of birth ____/____/____ Sex _____
Address _____
Parent/Guardian _____
Allergies _____
Date of last eye exam _____ Glasses/Contacts? _____
Current illness or special conditions _____

Immunizations – Date Received (You may attach shot records)

DTP/ 1. _____
DtaP 2. _____
3. _____
B. _____
*B. _____

POLIO(IPV/OPV)
1. _____
2. _____
3. _____
B. _____
*B. _____

MMR _____

The dates must be documented
by a physician.

HIB _____

**Substantiated by document
attached from Doctor**

Varicella (chicken pox) _____

***Hepatitis B _____

Hepatitis A _____

Meningitis Vaccine _____

PCV7 (Pneumococcal) _____

Signature of Physician or Nurse _____ **Date** _____

*Students **five** years of age and older must have received **one dose or booster** on or after their **fourth** birthday.

Signatures Required (See reverse side also)

For 1st time enrollment at Memorial Lutheran School

This is to certify that the above named child is free from communicable disease and is physically able to participate in the school program, having been examined by me within 12 months prior to the date of admission.

Name of examining Physician _____

Signature of Physician _____ Date ____/____/____

Consent for Emergency Medical Treatment

I give permission to the Principal or other designated school official to call my Physician or if he/she cannot be reached another qualified Physician, in the event that I myself cannot be reached in a medical emergency.

When necessary I give permission to take my child to the emergency room of the hospital in the event that neither my Physician, nor I can be reached, to seek medical attention for the above named child.

Signature of Parent/Guardian

Date

Name of Physician _____

Hospital or Clinic _____

Address _____

Phone Number _____