

**First Presbyterian Christian Preschool  
1340 Murchison, El Paso, TX 79912**

**IMMUNIZATIONS AND HEALTH RECORD**

**CHILD'S NAME:** \_\_\_\_\_

**DATE OF BIRTH:** \_\_\_\_\_ **AGE:** \_\_\_\_\_

|                    |              |                |                 |                |                |
|--------------------|--------------|----------------|-----------------|----------------|----------------|
| <b>Hepatitis B</b> | <b>#1</b>    | <b>#2</b>      | <b>#3</b>       |                |                |
| <b>Age</b>         |              |                |                 |                |                |
| <b>Date</b>        |              |                |                 |                |                |
| <b>DTaP</b>        | <b>#1</b>    | <b>#2</b>      | <b>#3</b>       | <b>#4</b>      | <b>Booster</b> |
| <b>Age</b>         |              |                |                 |                |                |
| <b>Date</b>        |              |                |                 |                |                |
| <b>Hib</b>         | <b>#1</b>    | <b>#2</b>      | <b>#3</b>       | <b>#4</b>      |                |
| <b>Age</b>         |              |                |                 |                |                |
| <b>Date</b>        |              |                |                 |                |                |
| <b>IPV</b>         | <b>#1</b>    | <b>#2</b>      | <b>#3</b>       | <b>Booster</b> |                |
| <b>Age</b>         |              |                |                 |                |                |
| <b>Date</b>        |              |                |                 |                |                |
| <b>RV</b>          | <b>#1</b>    | <b>#2</b>      | <b>#3</b>       |                |                |
| <b>Age</b>         |              |                |                 |                |                |
| <b>Date</b>        |              |                |                 |                |                |
| <b>PCV</b>         | <b>#1</b>    | <b>#2</b>      | <b>#3</b>       | <b>#4</b>      |                |
| <b>Age</b>         |              |                |                 |                |                |
| <b>Date</b>        |              |                |                 |                |                |
| <b>MMR</b>         | <b>#1</b>    | <b>Booster</b> |                 |                |                |
| <b>Age</b>         |              |                |                 |                |                |
| <b>Date</b>        |              |                |                 |                |                |
| <b>Varicella</b>   | <b>#1</b>    |                |                 |                |                |
| <b>Age</b>         |              |                |                 |                |                |
| <b>Date</b>        |              |                |                 |                |                |
| <b>Hepatitis A</b> | <b>#1</b>    | <b>#2</b>      |                 |                |                |
| <b>Age</b>         |              |                |                 |                |                |
| <b>Date</b>        |              |                |                 |                |                |
| <b>TB</b>          | <b>Date:</b> | _____          | <b>Results:</b> | _____          |                |
| <b>Other</b>       |              |                |                 |                |                |

**PHYSICIAN'S VERIFICATION OF MEASLES/MUMPS ILLNESS**

**This is to verify that the child named above had:**

**Measles illness on or about \_\_\_\_\_ (Month & Year) and does not need the vaccine(s).**

**Mumps illness on or about \_\_\_\_\_ (Month & Year) and does not need the vaccine(s).**

**Describe any special problems noted during the examination (allergies, asthma, etc.)**

\_\_\_\_\_

**I certify that the above named child is free of communicable disease and is physically and mentally able to participate in this program.**

\_\_\_\_\_  
Date

X \_\_\_\_\_  
Physician's Signature

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**VISION & HEARING SCREENING RECORD  
FOR 4 YEAR OLDS ONLY**

**Visual acuity and hearing sensitivity screening are required for 4 year olds enrolled in preschool. Rescreening is only required if is an abnormality was noted on the first screening.**

**Hearing Screening**

|                | <b>RIGHT</b> | <b>LEFT</b> |
|----------------|--------------|-------------|
| <b>500 Hz</b>  |              |             |
| <b>1000 Hz</b> |              |             |
| <b>2000 Hz</b> |              |             |
| <b>4000 Hz</b> |              |             |

**PASS**

**FAIL (Rescreen)**

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**Vision Screening**

|                         |                   |                   |
|-------------------------|-------------------|-------------------|
| <b>Distance Acuity:</b> | <b>R 20/_____</b> | <b>L 20/_____</b> |
|-------------------------|-------------------|-------------------|

**PASS**

**FAIL (Rescreen)**

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date