

St. Raphael Early Childhood Center
 5801 Falls of the Neuse Road, Raleigh, NC 27609
 (919) 865-5728 fax (919) 865-5701

HEALTH AND IMMUNIZATION REPORT

I authorize my child's physician to release the medical information requested below to St. Raphael ECC.

Parent Signature _____ **Date** _____
required

*This form must be **signed by the child's physician** and returned to the ECC Office before the child is permitted to attend school.*

Child's Name _____ Birth Date _____ Date of Last Exam _____

Health History and Medical Information: *(Please include any medical information that is important to safeguard this child's health during normal preschool activities or in a medical emergency.)*

Allergies (list all including latex): None Daily Medications: None

Health Restrictions: None Special Health Needs: None

Immunizations:

	Date	Date	Date	Date	Date
Hep B	#1	#2	#3		
DTP/DTaP	#1	#2	#3	#4	#5
Hib	#1	#2	#3	#4	
IPV	#1	#2	#3	#4	
PCV	#1	#2	#3	#4	
MMR	#1	#2			
Varicella	#1				

Physician's Signature _____ **Date** _____ Ph # _____
required