ST. MARK'S EPISCOPAL DAY SCHOOL

Austin, Texas

stmarksdayschoolaustin.org

Physician Signature Form

Last Name: _____ First: _____ MI: _____

Date of Birth: _____ Gender: ☐ M ☐ F
(mm/dd/yy)

Child's Doctor:

Name: _____

Address: _____

Phone: _____

(This section to be completed by physician)

Physical Examination:

I certify that I have examined _____ within the past year and find that he/she is in good health
(name of child)
and physically able to take part in the Preschool program.

List any health conditions the school should be informed of (i.e., allergies, dietary restrictions, vision or hearing

difficulties, seizures, etc.): _____

_____ _____

Physician's Signature (required) **Date**

Immunizations: ** ATTACH YOUR CHILD'S CURRENT IMMUNIZATION RECORDS SIGNED/STAMPED BY PHYSICIAN

The following immunizations are required:

Immunization	# of Doses required
DTP/DTaP/DT/Td	4*
MMR	1
Polio/IPV	3*
HepB	3*

Immunization	# of Doses required
HepA	2*
Hib	3*
Varicella	1
Pneumoccocal/PCV	4*

**Number of rounds dependent on age of child. Consult pediatrician for verification or link below for TX minimum requirements, https://www.dshs.texas.gov/immunize/school/child-care-requirements.aspx.*
***For further information regarding St. Mark's Immunization Policy, please see link, https://static.spacecrafted.com/aeaed74d0da14d02a1d11eafe841f4b4/r/df93cc22d6314e89bf99c8885c527edb/1/St.%20Marks%20Immunization%20Policy.pdf*