THE HEIGHTS CHILD DEVELOPMENT CENTER

HEALTH ADMISSION REQUIREMENTS

2024-2025 School Year

Child's Name: _____ Date of Birth: _____ Today's Date: _____

IMMUNIZATION REQUIREMENT: (Check One)

☐ Attached is a copy of the Immunization Records for the child listed above. I understand that it is my responsibility to bring updated records to the office throughout the year as immunizations are administered.

☐ I am excluding my child from the immunization requirements for reasons of conscience, including a religious belief. I have attached an official notarized affidavit form developed and issued by the Department of State Health Services. I understand this affidavit is valid for two years.

STATEMENT OF HEALTH REQUIREMENT

One of the following must be presented when your child is admitted to the CDC program, or within one week of admission.

1. ☐ A PHYSCIAN'S STATEMENT *with signature* is attached.

2. ☐ AFFIDAVIT: stating that medical diagnosis and treatment conflict with the tenants 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.* Parent's Initials: _____

3. ☐ PHYSCIANS STATEMENT: I have examined the above named child within the past year and find that he/she is physically able to take part in the preschool program. ****PHYSICIAN SIGNATURE REQUIRED**

_____ _____

PHYSICIAN SIGNATURE DATE

_____

Please Print: Physician Name/Physician Address/ Physician Phone Number

HEARING AND VISION REQUIREMENT

4 & 5 YEAR OLDS ONLY AS OF SEPTEMBER 1ST

(Please check only one option)

☐ I have attached a copy of the hearing and vision screening results for the above named child.

☐ Results for the hearing and vision screening are as follows:

VISION: **R** 20/_____ **L** 20/_____ ☐ **PASS** ☐ **FAIL**

HEARING: **1000HZ** **2000HZ** **4000HZ**

R: _____/ _____/ _____ ☐ **PASS** ☐ **FAIL**

L: _____/ _____/ _____

_____ _____

PHYSICIAN SIGNATURE DATE