

Please return this form within 1 week of enrollment date along with current immunization record

AHCS
9550 Leopard
Corpus Christi, TX 78410
Phone (361) 241-4460
Fax (361) 242-9284

HEALTH STATEMENT

Name of Child _____ Birth Date _____

Child had chicken-pox (approximate month and year) ____/____ or vaccine ____/____

To be completed for Preschool and Kindergarten Children Only

Physician's Health Statement

I have examined the above child and found him/her to be free of infectious or contagious diseases and physically able to participate in all school activities. His/her immunizations are up to date.

Physician's Signature

Date

Physician's Comments: _____

*This form must be returned **within 1 week of enrollment date** along with a copy of child's current immunization record. (*Texas Department of Protective and Regulatory Services Minimum Standard 2200*)