Louise Hayem Manheim
GATES PRESCHOOL

IMMUNIZATION FORM
2022–2023

TO BE FILLED OUT BY PHYSICIAN

Please have your child's physician complete and fax this form to 504.885.2603 or deliver to Gates Preschool's Office before your child's first day of school.

Child's Name: _____ Date of Birth: _____

Child's Physician: _____ Physician Phone: _____

Immunization	Date 1st	Date 2nd	Date 3rd	Date 4th	Date 5th
DTaP					
IPV					
HIB*					
HEP B*					
MMR					
VAR**					
PCV7					
ROTA VIRUS					

*Indicate if Comvax was given (HIB and HEP B)
**Indicate if child has had chicken pox disease or vaccine

Height: _____ Weight: _____

What is the general condition of child's health? _____

Can this child participate in all activities? _____

Additional Information: _____

I have examined the above named child on _____ and find him/her to be in satisfactory condition. He/She may engage in all usual activities except as noted.

_____

Physician Signature Date