CHILD'S STATEMENT OF HEALTH STATUS FOR ENROLLMENT IN A CHILD CARE FACILITY

The preschool facility must obtain for every child who enrolls in a preschool program, a signed and dated statement of the child's current health status which indicates the child's abilities and/or limitations to participate in a regularly scheduled preschool program. This report is to be filed out by a licensed physician or other health care professional (PA or Advanced practice nurse) who has performed a full well child check on the child in the past 12 months. This statement must be resubmitted during the school year at the time of the child's regularly scheduled well child visit, to be kept current.

Name of Facility_____ Type of Facility_____

Child's Name_____ Sex_____ Date of Birth_____

Address_____

Past Illnesses-check those the child has had and give approximate dates:

Chicken Pox_____ Rubeola_____ Rubella_____

Rheumatic Fever_____ Asthma_____ Hay Fever_____

Diabetes_____ Mumps_____ Epilepsy_____

Whooping Cough_____ Poliomyelitis_____ Other_____

Comments: _____

Surgery/Accidents/Illnesses/Chronic Health Problems: _____

_____

Describe any physical condition requiring the facility's special attention: _____

_____

Medication(s) prescribed: _____

Allergies: _____ and prescribed routine: _____

If tuberculin test given: Date_____ Result_____

If chest x-ray taken: Date_____ Result_____

Vision_____ Hearing_____

Please record immunizations and dates administered on the Colorado Department of Health Certificate of Immunization and attach this form:

Date of my most recent examination of the child: _____

_____ _____

Signature of licensed physician or other health care professional Date

Please print: _____

Name of Physician/Health Care Professional

_____

Address City State

_____

Zip Phone

COLORADO LAW REQUIRES THAT THIS FORM BE COMPLETED FOR EACH STUDENT ATTENDING COLORADO SCHOOLS

Name _____ **Date of Birth** _____

Parent/Guardian _____

COLORADO DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT—CERTIFICATE OF IMMUNIZATION

Vaccine		Enter the month, day and year each immunization was given					
Hep B	Hepatitis B						
DTaP	Diphtheria, Tetanus, Pertussis (pediatric)						
DT	Diphtheria, Tetanus (pediatric)						
Tdap	Tetanus, Diphtheria, Pertussis						
Td	Tetanus, Diphtheria						
Hib	*Haemophilus influenzae* type b						
IPV/OPV	Polio						
PCV	Pneumococcal Conjugate						
MMR	Measles, Mumps, Rubella						
Varicella	Chickenpox			Healthcare Provider Documentation Date _____		Lab Verification Date _____	
Vaccines recorded below this line are recommended. Recording of dates is encouraged.							
HPV	Human Papillomavirus						
Rota	Rotavirus						
MCV4/MPSV4	Meningococcal						
Hep A	Hepatitis A						
TIV/LAIV	Influenza						
Other							

THIS SECTION CAN BE COMPLETED BY CHILD CARE/SCHOOL/HEALTH CARE PROVIDER

☐ **A) Child Care Up to Date**
Up to date through 6 months of age for Colorado School Immunization Requirements — Update Signature _____ Date _____

☐ **B) Child Care Up to Date**
Up to date through 18 months of age for Colorado School Immunization Requirements — Update Signature _____ Date _____

☐ **C) Child Care/Pre-school/Pre-K***
Up to date for Child Care/Pre-School/Pre-K for Colorado School Immunization Requirements — Update Signature _____ Date _____

☐ **D) Complete for K–5th Grade**
Up to date for K–5th Grade for Colorado School Immunization Requirements — Update Signature _____ Date _____

* If age 4 years and fulfills Requirements for Pre-School & Kindergarten, check BOTH Boxes C and D.

HAS MET ALL IMMUNIZATION REQUIREMENTS FOR COLORADO SCHOOLS (6TH GRADE OR HIGHER)

Signed _____ (Physician, nurse, or school health authority) Title _____ Date _____

STATEMENT OF EXEMPTION TO IMMUNIZATION LAW (DECLARACIÓN RESPECTO A LAS EXENCIONES DE LA LEY DE VACUNACIÓN)

IN THE EVENT OF AN OUTBREAK, EXEMPTED PERSONS MAY BE SUBJECT TO EXCLUSION FROM SCHOOL AND TO QUARANTINE.
SI SE PRESENTA UN BROTE DE LA ENFERMEDAD, ES POSIBLE QUE A LAS PERSONAS EXENTAS SE LES PONGA EN CUARENTENA O SE LES EXCLUYA DE LA ESCUELA.

MEDICAL EXEMPTION: The physical condition of the above named person is such that immunization would endanger life or health or is medically contraindicated due to other medical conditions.
EXENCIÓN POR RAZONES MÉDICAS: El estado de salud de la persona arriba citada es tal que la vacunación significa un riesgo para su salud o incluso su vida; o bien, las vacunas están contraindicadas debido a otros problemas de salud.

Signed (Firma) _____ Physician (Médico) Date (Fecha) _____

***Medical exemption** to the following vaccine(s):*
***La exención por razones médicas** aplica a la(s) siguiente(s) vacuna(s):*

☐ Hep B ☐ DTaP ☐ Tdap ☐ Hib ☐ IPV ☐ PCV ☐ MMR ☐ VAR

RELIGIOUS EXEMPTION: Parent or guardian of the above named person or the person himself/herself is an adherent to a religious belief opposed to immunizations.
EXENCIÓN POR MOTIVOS RELIGIOSOS: El padre o tutor de la persona arriba citada, o la persona misma, pertenece a una religión que se opone a la inmunización.

Signed (Firma) _____ Parent, guardian, emancipated student/consenting minor (Padre, tutor, estudiante emancipado o consentimiento del menor) Date (Fecha) _____

***Religious exemption** to the following vaccine(s):*
***Exención por motivos religiosos** de la(s) siguiente(s) vacuna(s):*

☐ Hep B ☐ DTaP ☐ Tdap ☐ Hib ☐ IPV ☐ PCV ☐ MMR ☐ VAR

PERSONAL EXEMPTION: Parent or guardian of the above named person or the person himself/herself is an adherent to a personal belief opposed to immunizations.
EXENCIÓN POR CREENCIAS PERSONALES: Las creencias personales del padre o tutor de la persona arriba citada, o la persona misma, se oponen a la inmunización.

Signed (Firma) _____ Parent, guardian, emancipated student/consenting minor Date (Fecha) _____

***Personal exemption** to the following vaccine(s):*
***Exención por creencias personales** de la(s) siguiente(s) vacuna(s):*

☐ Hep B ☐ DTaP ☐ Tdap ☐ Hib ☐ IPV ☐ PCV ☐ MMR ☐ VAR