



**Spring Woods Weekday Ministries for Children**

**1711 FM 1960 West / P.O. Box 73564**

**Houston, Texas 77090**

**281-893-2241 / Fax : 281-444-5825 [www.sw-umc.org](http://www.sw-umc.org)**

**Physician's Statement**

I have examined \_\_\_\_\_ to see that this child is able to participate in the activities at Spring Woods Weekday Ministries for Children.

I have noted the following ( if applicable): \_\_\_\_\_

\_\_\_\_\_

Restrictions of activity :

\_\_\_\_\_

\_\_\_\_\_

Special attention or care needed : \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_  
Physicians' Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Address

\_\_\_\_\_  
Telephone

**PLEASE REFER TO FOLLOWING PAGE FOR FURTHER INFORMATION**

**Please attach a copy of the child's immunization record to include:**

**Hepatitis B ( birth, 2 months, 6 months)**

**DTaP and Hib ( 2months,4 months, 6 months, 15-18 months)**

**DTaP ( after 4<sup>th</sup> birthday)**

**PolioIPV ( 2 months, 4 months, 6 months and 4 years)**

**MMR ( 12-15 months, 4-6 years, 11-12- years)**

**Varicella ( 12 months )**

**Hepatitis A ( 2 doses, 12 months and 6 months after initial dose)**

**Pevnar ( 2 months, 4 months, 12-15 months)**

\_\_\_\_\_ DATE \_\_\_\_\_

Parent / Guardian signature that confirms that the child's immunization record is a current copy.

**Vision/ Hearing Screening**

**(Required for Four and Five Year Olds)**

**Vision Screening                      Left: \_\_\_\_\_                      Right: \_\_\_\_\_**

**Hearing Screening                      Left: \_\_\_\_\_                      Right: \_\_\_\_\_**

**Physicians Initials (\_\_\_\_\_)**