Lil Foxes Learning Center
(903) 527 - 4444

4150 I-30 W
Caddo Mills, TX
75135

Authorization For Emergency Medical Care

If I cannot be reached to make arrangements for emergency medical care for my child at the time of an illness or accident, I give permission for Lil Foxes Learning Center and its staff to take my child:

Child's Name: ____ Date of Birth: ____________________________

To:

Name of Doctor: ____

Address: ____

Or to:

Name of Hospital: ____

Address: ____

Please list any known allergies or illness that would conflict with emergency care or treatment:

____

____

____

Parent Signature ____ Date _________________________________

Please attach a current photo of your child

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Physician's Statement

Childs Full Name ____________________________________ Date of Birth ____________________________________

I have examined the above child within the past year and find that he / she is able to take part in the preschool program.

Health Care Professional Name ____

Address __________________________________ City _________________________ State ________ Zip ___________

Signature ____ Date _________________________________

Age Vaccine	Birth	1 mos	2 mos	4 mos	6 mos	12 mos	15 mos	18 mos	19-23 mos	2-3 yrs	4-6 yrs
Hepatitis B											
Rotavirus											
Diphtheria, Tetanus, Pertussis											
Haemophilus Influenzae Type B											
Pneumococcal											
Inactivated Poliovirus											
Influenza											
Measles, Mumps, Rubella											
Varicella											
Hepatitis A											
Meningococcal											

Signature or Stamp of a physician or public health personnel verifying immunization information above.

Signature ____ Date _________________________________

Varicella (chickenpox) vaccine is not required if your child has had chickenpox disease. If your child has had chickenpox, please complete the statement: My child has had varicella (chickenpox) on or about (date) _______________________ and does not need varicella vaccine.

Parent Signature ____ Date ____________________________________

Complete ONLY if applicable

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 2 years. Medical diagnosis and treatment conflict with the tenets 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 Signature ____ Date ____________________________________