IMMUNIZATION RECORD

IMR - **4**

Child's Name: _____

Date of Birth: _____ Age: _____ (As of Sept. 1, 2024)

Program Days: ◯ T/TH ◯ M/W/F ◯ M-F

<u>IMPORTANT</u> Any child on a delayed immunization schedule for medical reasons will be **required** to submit a letter signed by a physician stating the reasons for the delay in addition to the immunization record.

PLEASE ATTACH A <u>PHYSICIAN SIGNED</u> COPY OF IMMUNIZATION RECORDS

IF THE CHILD IS 4 YEARS OLD OR ABOVE, PLEASE ATTACH A COPY OF THE HEARING AND VISION SCREENING RESULTS, IF AVAILABLE.

(Please include the visual acuity and auditory sweep check results.)

****

Immunizations Records Attached? ☐ **YES** ☐ **NO**

Hearing and Vision Screening Results Attached? ☐ **YES** ☐ **NO**

****

Fax to CtR Genesis ECP at:
281-469-8441