Use this form if your child has NOT attended school with us 😊

FIRST BAPTIST K.I.D.S.

225 Keller Parkway, Keller, TX 76248
Phone: 817.431.4749 Fax: 817.431.4763

2020 - 2021 New Student

CHILD'S NAME: ______________________________ DATE OF BIRTH: __________________

IMMUNIZATION RECORD:

Please provide a current immunization record from your child's physician. Your pediatrician's office is welcome to fax this directly to FBC KIDS Preschool at 817-431-4763. Please note that this is required for your child to attend school.

The immunization record must include:

1. The child's name and birth date
2. The number of doses and vaccine type
3. The month, day and year the child received each vaccination
4. The signature or stamp of the physician or health professional who administered the vaccine.

VISION AND HEARING FOR 4 & 5 YEAR OLDS: (State of Texas Requirement)

The following must be filled out and signed by a physician - requirement for all 4 or 5 year olds enrolled in a state licensed childcare facility in Texas. Children who turn 4 during the school year are required to have this testing done as soon as possible.

____I have attached a copy of my child's Vision and Hearing Screening results. **Results for vision must include distance acuity (20/20, 20/30, etc.) and hearing must include hearing frequencies (1000, 2000, 4000 Hertz). Doctor may note that child could not be tested for Vision and/or Hearing. **Documentation must have a doctor's stamp or signature.**

OR

____I am using this form for Vision and Hearing Screening results: **Doctor signature/stamp required**

Vision Test Results:
Left Eye: ___________
Right Eye: ___________
Pass _____ Fail_____
Referred ___________

Hearing Test Results:
Pass __________
Fail ___________
Referred _________

My child could not be tested (please circle) Vision Hearing

Doctor Signature: ______________________________ **Date:** ______________________

NEW STUDENT HEALTH STATEMENT:

My child has been examined within the past year by a health care professional and is able to participate in the KIDS program. Within 12 months of admission, I will obtain a health care professional's signed statement and will submit it to the KIDS program.

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Health Care Name Address City State Zip

Parent's Signature: ______________________________ **Date:** ______________________