

1 FACILITY INFORMATION				
Facility Name: Facility Facility Number: Type: private public headstart		•	Administer/Principal:Facility Email:	
		•		
County:		•		
2 DESIGNATED FACILLITY CON	ГАСТ			
Name:				
Information Email:				
Phone Number:				
FACILITY STAFF MEMBER CO	OMPLETING THIS FORM			
Name:				
Summary Email:				
Phone Number:				
Report Submitted Date: _				
Total number of Children:				
Report on ages 2-5 years				
JNCONDITIONAL ADMISSION:				
Requirements Met				
• All required immunizations	A			
/ III required IIIIIII allizations	Λ			
Requirements Met, But Missing Do	nses	Missing Dosos Pul/as	reina	
		Missing Doses By Vac		
Personal Belief Exemption	E Pre 2016		Students are missing doses. Please indicate the total number of students	
Permanent Medical Exemption	С	missing each vaccine:	number of students	
IEP Services	F1	Polio	Нер В	
			-	
		DTP	Varicella	
CONDITIONAL ADMISSION, NEED FO	LLOW-UP:	MMR	Hib	
Conditional Entrant	В			
Not including Temporary Medical Exemptions				
Temporary Medical Exemption	D			
REQUIREMENTS NOT MET, MISSING D	OSES			
Overdue	G			
Previously Known as Enrolled But Not Attending				
TO'	ΓAL			
10				