FACILITY INFORMATION Facility Name: Facility Number: Type: private pu County: DESIGNATED FACIILITY CONT. Name: Email: Phone Number: FACIILITY STAFF MEMBER CO Name: Email: Email:	headstart ACT MPLETING THIS FORM	Facility Email: Physical Address:	
Phone Number:			
Total number of Children: Report on ages 2-5 years			
INCONDITIONAL ADMISSION: Requirements Met All required immunizations	Α		
Requirements Met, But Missing Do	ses	Missing Doses By Vacc	
Personal Belief Exemption Permanent Medical Exemption	E	Students are missing doses. Please indicate the total number of students missing each vaccine:	
IEP Services	F1	Polio	Hep B Varicella
CONDITIONAL ADMISSION, NEED FOL	LOW-UP:	MMR	Hib
Conditional Entrant Not including Temporary Medical Exemptions	В		
Temporary Medical Exemption	D		
REQUIREMENTS NOT MET, MISSING D	OSES		
Overdue Previously Known as Enrolled But Not Attending	G		
тот	AL		