Child Medical Statement

Childs' Name _____ Date of Birth _____

Height _____ Weight _____

Limitations or health condition (including allergies, medications, dietary restrictions)

Immunizations: Please check one

Complete for age ☐Yes ☐No

In Process ☐Yes ☐No

Exempt from Immunizations: Please check one

Religious conviction ☐Yes ☐No

Health concern ☐Yes ☐No

Other: _____

This child has been examined and is in suitable condition to participate in group care

_____

Signature of examining (check one)

☐Physician, ☐Physician's Assistant or ☐Advanced Practice Nurse

Address : _____

Phone: _____ Date of exam _____

Required for children enrolled in an Early Childhood Education Grant Program or Preschool Special Education Program			Reason not completed (Check which applies)	
Assessments/ Screenings	Completed **Please check one**	Date Completed	Examples: religious conviction, insurance coverage, other	Health professional decision
Vision	☐Yes ☐No			
Hearing	☐Yes ☐No			
Dental	☐Yes ☐No			
Lead	☐Yes ☐No			
Hemoglobin	☐Yes ☐No			

9/20/10