

STATEMENT OF HEALTH

Child's Name: _____ Sex: male female

Date of Birth: _____

Address: _____

The daily program involves both vigorous and quiet play. Describe any physical or emotional condition requiring the facility's special attention while in our care.

None:

Allergies:

Dietary Restrictions:

Date of most recent examination: _____

Physicians Signature

Date

Please attach a copy of the child's immunization record, signed or stamped by a physician or health care professional.