Child Medical Statement

To be completed by physician

Child's Name _____ Date of Birth_____

Height _____ Weight _____

Limitations or health conditions (including allergies, medications, and dietary restrictions)

Attach a copy of the child's immunization record with dates of doses of all immunizations

Immunizations	Please Circle One	
Complete for age	Yes	No
In Process	Yes	No

Exempt from Immunizations	Please Circle One	
Religious Conviction	Yes	No
Medically Contraindicated	Yes	No

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 circle one		Date Completed	Health Professional Decision	Other (Examples: religious conviction, insurance coverage, etc.) Please explain
Vision	Yes	No			
Hearing	Yes	No			
Dental	Yes	No			
Lead	Yes	No			
Hemoglobin	Yes	No			

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

Signature of Examining Physician/Physician's Assistant or Advanced Practical Nurse (Circle One)	Date of Exam:
Address: Phone:	