



Cypress-Fairbanks Independent School District

Early Learning Center PHYSICIAN RELEASE STATEMENT

Child's Name _____

DOB _____

This is to certify that the above child named has been examined by me on ____/____/____
(date). This child is found to be in good health and able to fully participate in the Cypress-Fairbanks Independent School District Early Learning Center program.

Physician's Signature

Date

Facility Address

Facility Phone Number

Submit this form by uploading it to your online account upon registering your child or email to earlylearningcenter@cfisd.net.