Lockhart ISD Cub House Child Development Center
Health Care Professional Verification of Care Statement

Child's Name _____ Date of Birth ____/____/____

The Texas Department of Family and Protective Services requires verification of ongoing health care for children entering day care. Please read and complete the following statement and return this form to the child's parent.

I, _____, confirm the child named above has, within the past 12 months, been examined by me or one of my fellow physicians at this practice. In addition, I confirm he/she is physically able to participate in the programs and activities provided by Lockhart ISD Cub House Child Development Center.

_____ _____
Physician's Signature *Date Signed*

_____ _____
Address *Phone Number*

Please add any exceptions or precautions regarding the child's participation:
_____
_____
_____

*Doctors office information stamp must be here for this form to be valid.