

Health Statement

Child's Name _____ Date of Birth _____

Address _____

Street Address

P.O. Box

City

State

Zip

Mother's Name _____

Father's Name _____

TO BE COMPLETED BY A PHYSICIAN OR RN:

Status of Child's Health:

____ Satisfactory

____ Other: _____

List any known conditions under treatment: _____

Is the child capable of adjusting to programs of a school facility?

Signature of Physician or RN

Date

Physician's Address

Phone