

Health-Care Professional's Statement

Child's Name _____

Date of Birth _____

Address _____ Zip _____

Phone _____

Health-Care Professional's Name _____

Address _____ Zip _____

Phone _____

_____ I have examined the above named child within the past year and find that he/she is physically able to take part in the preschool program.

_____ The above named child's immunizations are current, as of today's date.

Health-Care Professional's Signature

Date

If you have any questions, please contact the school at (979) 968-5913.