

Preschool Director: Janice Teinert
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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.

X _____
Health-Care Professional's Signature

X _____
Date