Physician's Health Statement

Child/Applicant Name: _____

DOB: _____

Statement of Health To be completed by Physician

I have examined the child named above and to the best of my knowledge; he/she is in good physical and mental health, free of any communicable diseases and is able to child care.

By signing below, I certify that the above information is true.

Name (printed): _____

Signature: _____

Office Phone Number: _____

Date of Exam: _____

Office Address:

_____

_____

_____

Office Stamp (if available)