

Child Medical Statement

Childs' Name _____ Date of Birth _____

Height _____ Weight _____

Limitations or health condition (Including allergies, medications, dietary restrictions)

Chronic Physical Problem (S):
History of Hospitalization
Diseases the child has had:
Allergies and Treatment:
Medications, Food Supplements, or Modified Diet:

Immunizations	Please circle one	
Complete for age	Yes	No
In Process	Yes	No

Exempt from Immunizations	Please circle one	
Religious Conviction	Yes	No
Health Concern	Yes	No
Other:		

Parent or Guardian Signature for immunization exemption:

X _____

This child has been examined and is in suitable condition to participate in group care

Signature of examining Physician/Physicians Assistant or Advanced Practice Nurse (Circle One) Address: Phone:	Date of Exam
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Please Attach a Copy of the Child's Immunization Record