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**

Please Attach a Copy of the Child's Immunization Record