Child Medical S	Statement
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Childs' Name		_ Date of Birth
Height	Weight	
Limitations or health	condition (including allergies, me	edications, dietary restrictions)

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:		

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)	Date of exam
Address :		
Phone:		

Required for children enrolled in an Early Childhood Education Grant Program or Preschool Special Education Program			Reason not completed (Check which applies)		
Assessments/Screenings	Completed Date Please circle one Comp		Date Completed	Health professional decision	Examples: religious conviction, insurance coverage, other
Vision	Yes	No			
Hearing	Yes	No			
Dental	Yes	No			
Lead	Yes	No			
Hemoglobin	Yes	No			