Lil' Cat's Preschool

Health Statement

Please Do Not Attach Child's Immunization Record

Child's Name (Please print legibly)	Date of Birth

PHYSICIAN/CERTIFIED NURSE PRACTITIONER PLEASE COMPLETE 1-4 BELOW; SIGN & DATE

1) List any limitations, health conditions or allergies _____

_____

_____

2) List any medications and/or drugs taken regularly by the child _____

_____

_____

3) The above named child is currently under my care and is up to date with his/her immunizations.

PLEASE (√) APPROPRIATE RESPONSE ___YES ___ Exemption affidavit is attached.

4) I have examined the above named child within the past year and find that he/she is in suitable condition for participation in group care.

Signature of examining Physician/Certified Nurse Practitioner	Date of Examination

Name of Physician/Certified Nurse Practitioner (Physician's Stamp)	Telephone Number ( ) -
Street Address	
City, State and Zip Code	