FAX: 512-369-4091

Child's Medical Statement

PHYSICIAN'S USE ONLY

Child's Name: ___________________________________

Date of Birth: _____/_____/_____

DATE OF WELLNESS EXAM: _____/_____/_____

This is to certify that I have examined this child and have found that: This child has had the immunizations required by the state of Texas for admission to school, or; has had the immunizations required by the department of health according to the child's age.

Please attach a copy of UPDATED IMMUNIZATION RECORDS

Special Requirements/Allergies/Modified Diet:	
Symptoms to Watch For: Conditions to Avoid:	Medical Procedures to Be Followed: Any Medications Required? ☐ NO ☐ YES

Name of medication: ____Exact dosage: ____________________

To be administered at the following times: ____

For the following period of time: ____

Name of medication: ____Exact dosage: ____________________

To be administered at the following times: ____

For the following period of time: ____

Vision and Hearing Test required at age 4 by September 1st

Vision Test	R 20/ _____________	L 20/ _____________	Pass: ____ Fail: ____	
Hearing Screening	1000 Hz	2000 Hz	4000 Hz	
Right:				Pass: __ Fail: __
Left:				Pass: __ Fail: __

Based upon medical history and physical condition at the time of this examination, this child is in suitable condition for participation in group care.

Name of Physician: (*please print*) ____ Telephone: ______________________________

Street Address: ____ City: _____________ State: ________ Zip: _____________

‘

Physician's Signature: ____Date of Physician's Signature: ____/____/____

I give my permission for the staff/nurse to perform the procedures listed in my Child's Medical Statement.

Parent's Signature: ____ Date: ____/____/____