FAX: 888-965-0758

DATE OF WELLNESS EXAM:

_____/_____/_____

Child's Medical Statement

PHYSICIAN'S USE ONLY

Child's Name: _____ Date of Birth: _____/_____/_____

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 Massachusetts 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 ***If YES, Please Fill Out an Authorization For Medication Form.***

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/Guardian's Signature: _____ Date: ____/____/____