St. Catherine
Early Childhood Education Center
Physician's Statement
2019-2020

Section I -Child Medical Information

Child's Name_____

Height_____ Weight_____ Birthdate_____ M F

Immunizations*:			Exempt from Immunizations:		
Complete for age	Y	N	Religious Conviction	Y	N
In Process	Y	N	Health	Y	N
*Please attach immunization report			Other_____		

Limitations or health restrictions, including allergies, medications and dietary restrictions.

Section II –Child Medical Statement Verification

Physician/Medical Provider Name_____

Address_____City_____ State _____

Phone_____

Check Box of Examining Medical Professional:

- ☐ Physician
- ☐ Physician's Assistant
- ☐ Advanced Practice Nurse

This child has been examined and is in suitable condition to participate in group care.

_____ _____
Signature of Medical Professional Date of Exam

___ Immunization record attached

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