



St. Catherine
Early Childhood Education Center
Physician's Statement
2020-2021

Section I -Child Medical Information

Child's Name _____ Birthdate _____	
Height _____	Weight _____ BMI _____ M F

Optional Recommended Screenings:		Vision	Y	N	Other _____
Hearing	Y	N	Lead	Y	N
Dental	Y	N	Hemoglobin	Y	N

Immunizations*:	Exempt from Immunizations:
Complete for age	Y N Religious Conviction
In Process	Y N Health
*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

