St. Catherine
Early Childhood Education Center
Physician's Statement

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 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