

| IDENTIFYING INFORMATION | | |
|---|---|-----------------------------------|
| CHILD'S NAME | | BIRTHDATE |
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| | | |
| CURRENT STATE OF HEALTH | | |
| | | |
| Based on my assessment of this child's medical history, current state of health and my physical examination of the child on /, | | |
| this child can participate in a child care program. This child has no special care needs unless specified below. | | |
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| (Date of medical examination must be within the last 12 months.) | | |
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| PHYSICIAN'S INSTRUCTIONS FOR SPECIALIZED CARE | | |
| Complete this section only if child requires special care at a child care facility, e.g. special diets, allergies, ear infections, convulsions, | | |
| diabetes, asthma, behavior problems, hearing or visual impairment, etc. (Attach additional pages as needed.) | | |
| diabetes, astima, benavior problems, nearing or visual impairment, etc. (Attach additional pages as needed.) | | |
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| SIGNATURE OF PHYSICIAN OR REGISTERED NURSE UNDER THE SUPERVISION O | F A PHYSICIAN DA | TE |
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| PHYSICIAN'S OR NURSE'S NAME (PLEASE PRINT) | | |
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| | | |
| NAME AND ADDRESS OF CLINIC, GROUP, PRACTICE OR OTHER (MAY USE STAMP.) | IF NURSE IS SUPERVISED BY A PHYS (PLEASE PRINT.) | SICIAN, INDICATE PHYSICIAN'S NAME |
| | (,/()_ ((((((((((((((((((| |
| | | |
| | TELEPHONE NUMBER | |
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