Health Statement from Physician

Child's Name: ____________________________

Date of Birth: ___________________________

I have examined the above named child within the past year and find that he / she is physically able to take part in the day care program.

For children 4 years and older:

VISION	Right 20/ _____	Left 20/ _____	☐ PASS ☐ FAIL

HEARING	1000 Hz	2000 Hz	4000 Hz
Right			
Left			

☐ PASS ☐ FAIL

_________________________________ _______________

Physician's Signature Date

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