MEDICAL STATEMENT TO BE COMPLETED BY PHYSICIAN

Date of Examination: _____

_____

Child's Name

4+ yr olds

VISION	R 20/ _____	L 20/ _____	☐ PASS ☐ FAIL
SIGNATURE _____		DATE _____	

HEARING	1000 Hz	2000 Hz	4000 Hz	
R				☐ PASS ☐ FAIL
L				
SIGNATURE _____		DATE _____		

_____ _____ _____

PHYSICIAN'S SIGNATURE ADDRESS TELEPHONE

MEDICAL STATEMENT TO BE COMPLETED BY PHYSICIAN

Date of Examination: _____

_____ has been examined by me and found free of

Child's Name

infectious and contagious disease and is physically and mentally able to participate in group activities.

Any allergies or special recommendations: _____

_____

_____

_____

_____ _____ _____

PHYSICIAN'S SIGNATURE ADDRESS TELEPHONE