

Health Form

This form must be completed by a medical doctor or registered nurse

Child's Name: _____ Date of Birth: _____

Parent's Name: _____

Parent's Address: _____

Status of the above child's health:

Any known conditions under treatment:

Child is capable of adjusting to programs of the child care facility: Yes No

Reason:

Name of MD/RN: _____ Telephone: _____
(please print)

Signature: _____ Date: _____