Office of Early Learning and School Readiness

Child Medical Statement

Childs' Name_____Date of Birth_____

Height_____Weight_____

Limitations or health condition (including allergies, medications, dietary restrictions)

Immunizations	**Please circle one**	
Complete for age	Yes	No
In Process	Yes	No

Exempt from Immunizations	**Please circle one**	
Religious conviction	Yes	No
Health concern	Yes	No
Other:		

This child has been examined and is in suitable condition to participate in group care

Signature of examining Physician/ Physicians Assistant or Advanced Practice Nurse (circle one) Address : Phone:	Date of exam

Required for children enrolled in an Early Childhood Education Grant Program or Preschool Special Education Program				Reason not completed (Check which applies)	
Assessments/Screenings	Completed **Please circle one**		Date Completed	Health professional decision	Examples: religious conviction, insurance coverage, other
Vision	Yes	No			
Hearing	Yes	No			
Dental	Yes	No			
Lead	Yes	No			
Hemoglobin	Yes	No			

ATTACH COPY OF IMMUNIZATION RECORDS