



Doctor's Statement

_____ has been examined by me on:
_____ and was found to be free of any contagious and transmittable diseases, and is physically able to participate in any of the child care programs.

Remarks: _____

Allergies/Asthma

Has allergies- (Circle) yes or no (If yes, please provide an action plan if needed and medicine)

Has asthma- (Circle) yes or no (If yes please provide an action plan if needed, medicine or inhaler)

Signature: _____ MD Printed Name: _____ MD

Address: _____ City: State: _____

Phone: _____ Date: _____