Well Check Form

Healthcare Professional Statement: I have examined the child named below within the past year and find that s/he is physically able to take part in the preschool/child care program.

Child's Name _____ **Date of Birth**_____

_____

Healthcare Professional's Signature

_____

Medical Office

_____

Street Address City Zip

*Note: You can call and request your doctor's office to FAX us a Well Check form. They typically have their own version, but you can FAX or drop this one off to them.

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