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 a 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.

Circle ONE before giving to your doctor's office:

Sunrise WEST's FAX number:

512.341.2884

Sunrise EAST's FAX number:

512.590.7195

Sunrise Montessori WEST: 104 Northwest Drive, Round Rock, TX 78664 * 512.341.2883 * 512.341.2884 FAX
Sunrise Montessori EAST: 60 Limmer Loop, Round Rock, TX 78665 * 512.846.1956 * 512.590.7195 FAX