Tabernacle Preschool
PHYSICIAN'S STATEMENT

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

Name of Physician _____

Physician's Address _____ Phone Number _____

City _____ State _____ Zip _____

To be completed by physician:

Is the child free of communicable disease? ☐ Yes ☐ No

Is the child able to participate in the preschool setting? ☐ Yes ☐ No

Is the child current on all immunizations? ☐ Yes ☐ No

List any medications and drugs taken regularly by the child.

_____

_____

_____

Restrictions of activity:

_____

_____

_____

Special attention or care needed:

_____

_____

_____

Signature of physician _____ *Date* _____

Please attach a copy of the child's immunization record to this form.