



| IDENTIFYING INFORMATION         |  |
|---------------------------------|--|
| 1. Name of the person or entity |  |
| 2. Address                      |  |
| 3. City                         |  |
| 4. State                        |  |
| 5. Zip                          |  |
| 6. Date                         |  |
| 7. Time                         |  |
| 8. Location                     |  |
| 9. Other                        |  |

BIRTHDATE

Based on my assessment of this child's medical history, current state of health and my physical examination of the child on \_\_\_\_ / \_\_\_\_ / \_\_\_\_, this child can participate in a child care program. This child has no special care needs unless specified below.

*(Date of medical examination must be within the last 12 months.)*

Complete this section only if child requires special care at a child care facility, e.g. special diets, allergies, ear infections, convulsions, diabetes, asthma, behavior problems, hearing or visual impairment, etc. (Attach additional pages as needed.)

[illegible]

|      |
|------|
| DATE |
|------|

PHYSICIAN'S OR NURSE'S NAME (PLEASE PRINT)

IF NURSE IS SUPERVISED BY A PHYSICIAN, INDICATE PHYSICIAN'S NAME  
(PLEASE PRINT.)

TELEPHONE NUMBER