Annual Physician Statement

Child's Name ______________________________ DOB _____________________

HEALTH CARE PROFESSIONAL'S STATEMENT: I have examined the above named child within the past year and find that he / she is able to take part in the day care program.

The child above has the following allergies:

____

You must fill out a Food Allergy Emergency Care Plan for severe allergies.

____ _______________________

Health Care Professional's Signature Date

Name and Address of Health Care Professional:

____

Vision and Hearing:
For children 4 years and older not enrolled in public school:

VISION	R 20/ ______		L 20/ ______	☐ PASS ☐ FAIL
SIGNATURE ______________________		DATE ______________________		
HEARING	1000 Hz	2000 Hz	4000 Hz	☐ PASS ☐ FAIL
R				
L				
SIGNATURE ______________________		DATE ______________________		

An updated copy of the child's immunizations must be attached.

BKP-Enrollment Forms-Annual Physician Statement-12/1818