Milford Christian Academy

Physician's Statement

Preschool Students Only

Child's Name Date of Birth This is to certify the following:

• I have examined this child and found that he or she is in suitable condition for participation in group care.

• The child has had the age appropriate immunizations recommended by the Ohio Department of Health.

• My office has attached a printed copy of the child's immunization record or found that the child should be exempt from immunizations for the following reason:

_____

_____

Please list any limitations or health conditions for this child (including allergies, daily medication, dietary restrictions):

_____

_____

Please list any recommended assessments/screenings (such as vision, hearing, etc.):

_____

_____

_____

Please attach a printed copy of the child's immunization record.

Signature of examining Physician/Physician's Assistant/Advanced Practice Nurse:	Telephone:
Name of examining Physician/Physician's Assistant/Advanced Practice Nurse:	Date of Examination:
Street Address:	
City, State, Zip Code:	