Medical Examination Statement
(To be completed by family physician)

Child's Name ________________________________
Birth date ____________________

Past health problems ____
Serious illnesses or accidents ____
Allergies ____
Has child had (give dates) Chicken Pox __________ Mumps _________Other ____
Height _______
Weight _______
TB Test: date ______ results _____

Immunizations:	Original Date	Booster Date
DPT	__________	___________
Polio	__________	___________
HIB	__________	___________
Hepatitis B	__________	___________
Measles	__________	___________
Mumps	__________	___________
Rubella	__________	___________
Chicken Pox	__________	___________

Is this child free from communicable and infectious disease and able to participate in a group program? Yes _______ No ________

Is this child able to participate in normal outdoor activity? Yes _____ No _____
If no, explain: ____
Special instructions, if any: ____

Physician's signature ____
Date ____________________________
Physician's phone number ___________________

Copy of Medical Insurance Card