Holy Rosary School Pre-Kindergarten

Office of Early Learning and School Readiness

Child Medical Statement

Child's Name _____ Date of Birth _____

Height _____ Weight _____

_____
_____
_____
_____

Immunizations	Please Circle One	
Complete for age	Yes	No
In Process	Yes	No

Exempt from Immunizations	Please circle one	
Religious conviction	Yes	No
Health Concern	Yes	No
Other:		

This child has been examined and is in suitable condition to participate in group care.

Signature of examining physician/Physicians Assistant or Advanced Practice Nurse (circle one)	Date of Exam
_____	
Address: _____	
Phone: _____	

For Office use only:

Date Received in Holy Rosary Office _____

04/2015