HEALTH STATEMENT

CHILD'S NAME:_____BIRTH DATE:_____

PARENT'S NAME:_____

PARENT'S ADDRESS:_____

STATUS OF THE ABOVE CHILD'S HEALTH_____

_____

ANY KNOWN CONDITIONS UNDER TREATMENT_____

_____

_____

CHILD IS CAPABLE OF ADJUSTING TO PROGRAMS OF THE CHILD CARE FACILITY

YES/NO REASON_____

_____

SIGNED_____ DATE_____
(M.D. OR R.N.)

Please email, fax or return this form, signed by a doctor and current immunization records to:

Email: sara@smallblessingsumc.org or britney@smallblessingsumc.org

Fax: (775) 882-5742

Mail: Small Blessings Preschool
400 W. King St, #100
Carson City, NV 89703