

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: smallblessingspreschool@gmail.com

Fax: (775) 882-5742

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