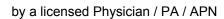
HEALTH EXAMINATION





Child's Name:			
Gender:	Birth date:	_	
Allergies:			
General physic	cal condition:		
Surgeries, acci	dents, chronic illnesses or special conce	erns:	
This form will ϵ	expire one year from the date of examina	ation unless indicated other	wise. Exp. Date:
The above chil YES \(\text{NO} \)	d was found free from communicable dis	sease and is medically fit to	attend group care situations:
Clinician name	/ signature:		Date:
Facility name (if applicable):		
Facility phone	number:	_	