

HEALTH EXAMINATION

by a licensed Physician / PA / APN



Child's Name: _____

Gender: _____ Birth date: _____

Allergies:

General physical condition:

Surgeries, accidents, chronic illnesses or special concerns:

This form will expire one year from the date of examination unless indicated otherwise. Exp. Date: _____

The above child was found free from communicable disease and is medically fit to attend group care situations:
YES NO

Clinician name / signature: _____ Date: _____

Facility name (if applicable): _____

Facility phone number: _____