**NEW STUDENTS ONLY**

# PHYSICIAN FORM

**DUE BEFORE START DATE**

**THIS FORM MUST BE COMPLETED BY A PHYSICIAN ONLY**

| Child's Name: | Date of Birth: |
|---|---|

**HEALTH CARE PROFESSIONAL'S STATEMENT**: I have examined the above named child within the past year and find that he or she is able to take part in the child care program at the ratio listed below.

**Class Ratios: Toddlers - 1:5, Two's/Young 3's - 1:6, Pre-K 3 - 1:7, Pre-K 4 - 1:7.**

**To be filled in by your child's doctor ONLY:**

1. Child's allergies: check one: **No known allergies _____** **Yes allergies _____**
   (please fill out additional "Food Allergy Emergency Plan" form at end of documents)
   _____

2. List any limitations or restrictions on the child's activies; special care the child requires, including:
   a. any reasonable accommodations or modifications,
   b. any adaptive equipment provided for the child, including instructions for how to use the equipment
   c. symptoms or indications of potential complications related to a physical, cognitive, or mental condition that may warrant prevention or intervention while the child is in care

   _____

   **N/A _____**

3. Child's previous (serious) illness(es) and injury: **N/A _____** **Yes _____ (list below)**
   _____

Is the child on any medications that are prescribed for long term use that would indicate that special care needs to be taken? **No _____** **Yes _____ (list below)**

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**I agree with the above information provided by my health care professional.**

**Parent Signature _____** **Date _____**

| **Name and Address of Health Care Professional** | |
|---|---|
| **Health Care Professional's Signature:** | **Date Signed:** |