MEDICAL STATEMENT

MEDICAL FORM FOR CHILDREN CURRENTLY IN THE HOME

Name of Child ____ Birth Date ______________________

To be completed by physician:

Is the child regularly the treated by you? Yes ( ) No ( )

If yes, what Medical Services have you provided? ____

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Does this child have any serious physical or emotional disorder or any major medical concerns? Yes ( ) No ( )

If Yes, please explain: ____

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Immunizations: Up to Date __________________________ Needs
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Signed ____

Physician

____

Address

____

City State Zip Code

____

Phone

____

Date