COMMUNITY OF FAITH
PRESCHOOL

PHYSICIAN SIGNED HEALTH STATEMENT
Immunizations, Hearing & Vision

The bottom section is only to be completed by Physician

Child's Name: (Last) _____ (First) _____

Date of Birth: _____ Female _____ Male_____
Please list, with instructions, any medications taken routinely and any side effects that we should be alerted to. There will be a separate Authorized Medication form you will need to complete.

_____

Any special care needed for allergies, diet, activity, or other chronic condition? *(must be the same information as on the Emergency Medical Care Treatment & Allergies form)*

_____

_____

Does this child have special needs: _____ Yes _____ No * If yes, please explain:

_____

IMMUNIZATIONS: *Initial One below*
_____ I am excluding my child from immunization requirements for reasons of conscience, including a religious belief. If yes, I have included and attached an official notarization affidavit.
_____ I have provided COF a current copy of my child's immunization record and confirm it is a legal document and accurate.

HEARING & VISION SCREENING: (ages 4+ only)
_____ I have provided COF a current copy of my child's hearing and vision screening results.
_____ I give permission for COF to have my child's hearing and vision screened by the Houston Cy-Fair Lions Club Kidsight Early Vision Screening Program (if COF if able to schedule) https://www.houstoncy-fairlions.org/ (if COF is able to schedule)

_____	_____	_____
Parent/Guardian Printed Name	**Parent/Guardian Signature**	**Date**

THIS STATEMENT OF CHILD'S HEALTH MUST BE COMPLETED BY THE PHYSICAN OR HEALTH-CARE PROFESSIONAL

This certifies that (Child's Name) _____ with the birthdate _____/_____/_____ has been examined by me, the named Physician below within the last 12 months and is physically and mentally able to participate in pre-school activities. This child can participate in all regular activities except: _____

_____

_____

Clinic Name/Dr Office Street Address City State Zip

_____

Doctor Phone Number

_____	_____
Physician's Signature / Stamp	***Date***