HEALTH STATEMENT

THIS HEALTH STATEMENT IS A REQUIREMENT OF THE LAW

PLEASE FILL OUT SEND IT TO YOUR PHYSICIAN AND RETURN WITHIN 5 DAYS

Child's Name:_____ DOB:_____ DATE:_____

Parent's Name:_____Phone#:_____,_____

Physician's Name:_____ Phone:_____
Address:_____ City: _____State:___

_____My child has been examined by a health-care professional within the past year, and is able to participate in the program at Burleson Child Development Center, Inc. I am aware I must submit a copy of this statement to my physician, and have them return it ASAP.

_____I have attached a written statement, from a health-care professional who has examined my child within the past 12 months, indicating the child is physically able to take part in your child-care program.

PHYSICIAN'S STATEMENT

I must submit a health care statement to Burleson Child Development Center, Inc., prior to enrollment or within 5 days. Please send in documentation that my child has been examined within the past year, and indicating my child is physically able to take part in the child care program.

_____ I have examined the child named above within the past 12 months, and the child indicated above is physically able to take part in the child care program

_____I have NOT examined the child named above within the past 12 months.

List any special problems or special care needs that the above child may have. Include allergies, existing illness, previous serious illness and injuries, hospitalizations during the past 12 months, and any medications prescribed for continuous, long-term use:

_____

Please check one statement above, sign and return to: Burleson Child Development Center, Inc., P. O. Box 848, Burleson, TX 76097, **OR** Fax to 817-426-5438, **OR** email to bcdcinc@yahoo.com. If you fax or email still **return original statement** to Burleson Child Development Center, P. O. Box 848, Burleson, TX 76097.

Physician Name:_____Address:_____City:_____State__

I_____, verify the above information is true and correct.

_____Physician Signature Phone#_____

Address:_____, City: _____State:_____

_____The medical diagnosis and treatment conflict with the tenets and practices of a recognized religious organization of which the parent is an adherent or a member. List the religious organization below:

Religious Organization:_____ Phone#_____

Address:_____, City: _____State:_____

I have read the above, checked the areas that are true and correct. I agree with a physical and will obtain one or documentation within 5 days or I have checked the religious area above.

_____Parent's Signature Date:_____