KINGDOM KIDS ACADEMY

PERFORMING & VISUAL ARTS

PEDIATRIC HEALTH STATEMENT

Child's Name:	Date:
○ This above-named child has been examined and is in suitable condition for participation in group care. ○ This above-named child has been immunized in accordance with Texas requirements. ○ This above-named child has not been immunized in accordance with Texas requirements.	
Doctors Office:	Telephone:
Name of Physician/PA/CNP:	Date of exam:
Signature of Physician/PA/CNP:	
Street Address	City
State	Zip
**** Please attach a copy of the shot records to this form ****	
○ I have declined to have my child immunized against one or more diseases. ** Please attach a signed, notarized affidavit.**	
Parent Signature:	Date: