Statement of Health – Completed by Health Care Provider

Child's Name: …… Date of Birth: …….

Significant Health Concerns:

- ☐ None
- ☐ Hearing
- ☐ Seizures
- ☐ Severe Allergies
- ☐ Developmental Delays
- ☐ Dietary Restrictions
- ☐ Other

Explain above concerns and, if necessary, include instructions to child care providers.

Are there restrictions to the child participating in any activities? YES NO

If yes, please describe.

I find, …….. to be in good health and able to attend Creative Avenues Learning Center.

…….. ……..

Physician Signature Date

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A copy of your child's immunization records must accompany this form