

Well Child Statement

Student Name:

Known Allergies:

Regular Medication Taken:

Other Medical Concerns/Considerations:

This is to certify that the above named individual has been examined by me on _____ and is found to be in good health and able to attend school, as well as participate in age appropriate physical activities.

Provider's

Signature: _____ Date: _____

Provider's Address: _____

Phone: _____

Please include an up-to-date immunization record