CHS - **5**

CHILD MEDICAL STATEMENT OF HEALTH

Program Days: ☐ T/TH ☐ M/W/F ☐ M-F

Age: _____ (As of Sept. 1, 2021)

THIS STATEMENT OF CHILD'S HEALTH MUST BE COMPLETED BY PHYSICIAN OR HEALTH-CARE PROFESSIONAL.

This certifies that _____ born _____
Child's Name Date of Birth
is in suitable condition for enrollment in a pre-school facility; and has immunizations required by law for infants and toddlers to be admitted to a pre-school program. This child is able to participate in all regular activities except:

_____

_____

_____

Clinic Name: _____

Address: _____

City, State, Zip: _____

Physician's Signature: _____Date: _____

Fax to CtR Genesis ECP at:
281-469-8441