PHYSICIAN'S HEALTH STATEMENT

Child's Full Name	Child's Date of Birth

PHYSICIAN'S HEALTH STATEMENT

I have examined the above named child within the past year and find that he / she is able to take part in the preschool program.

Physician's Name (Printed)	Address	Phone #
	City/State/Zip	

_____ _____

Physician's Signature **Date**

Hearing and vision screening is to be completed for students who are <u>four years of age (or older) by September 1st</u>.

HEARING AND VISION SCREENING RESULTS

VISION	R 20/ _____	L 20/ _____	☐ PASS ☐ FAIL
SIGNATURE _____		DATE _____	

HEARING	1000 Hz	2000 Hz	4000 Hz	☐ PASS ☐ FAIL
R				
L				
SIGNATURE _____		DATE _____		