MEDICAL DECLARATION STATEMENT FOR SCHOOL-AGE CHILD CARE

Child's Name: _____

Date of Birth: _____ Grade in September _____

Is your child under any medical/physical restrictions? _____Yes _____No
If yes, check all that apply:

_____Asthma _____Hearing Loss _____Diabetes _____ Convulsions

_____Other: _____

Is your child taking any medication? _____Yes _____No
If yes, please list:

_____

_____

Has your child been under a doctor's care or hospitalized within the last three years? _____Yes _____No
If yes, please explain:

_____

_____

Is your child allergic to any medications/foods/insect stings? _____Yes _____No
If yes, please list:

_____

_____

Family Health care provider's Name: _____

Telephone Number: (_____)_____

Address: _____

_____

As a parent/guardian of the above participating child, I certify that he/she is in good physical health, has no special needs, and may participate in all of the activities of the Center's program, except as noted above.

PARENT/GUARDIAN SIGNATURE: _____ DATE: _____