METHODIST WEEKDAY SCHOOL

PHYSICIAN'S STATEMENT

Child's Name ____

Child's Date of Birth ______________________________________

This child has been examined by me and found free of infection and contagious diseases and is physically and mentally able to participate in group activities.

Physician's Signature______________________________________

Physician's Name____

Date ____

Address ____

Phone____

State Licensing requires current immunizations and a signed Physician Statement for each child enrolled in our program.