CHS - **5**

# CHILD MEDICAL STATEMENT OF HEALTH

Program Days: ☐ T/TH ☐ M/W/F ☐ M-F

Age: _____ (As of Sept. 1, 2024)

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

**Child's Name: _____ Date of Birth: _____**

This certifies that I have examined the above named child within the past year and find that he or she 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**