St. Mary's Episcopal Day School
Health Statement

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Child's Name

HEALTH CARE PROFESSIONAL'S STATEMENT: I have examined the above named child within the past year and find that he/she is able to participate in the school's program without limitations.

__________________________ ____

Date Signature

Physician Name ____

Address ____

City/state/zip ____

Parent may sign and detach form below if child has been examined by a physician in the past 12 months and cleared for activities. Take the above portion to your next doctor's appointment and have physician sign; then return top portion to the school as soon as possible.

My child, ____________________________________, has been seen by a physician/health care provider in the past 12 months and is able to participate in the school's program without limitations.

Physician Name ____

Address ____

City/state/zip ____

____ ____________________

Parent's Signature Date