Almost Mom

State of Texas Licensed Home Child Care

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Health Statement Form

PHYSICIANS STATEMENT

Childs full name: ______________________________

Childs date of birth: __________________________

Childs address: ________________________________

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PHYSICIANS STATEMENT: I HAVE EXAMINED THE ABOVE NAMED CHILD WITHIN THE PAST YEAR AND FIND THAT HE/SHE IS PHYSICALLY ABLE TO TAKE PART IN THE CHILD CARE PROGRAM.

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PHYSICIANS SIGNATURE DATE

Physicians name:_________________________________

Phone number: __________________________________

Address: ____

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□ COPY OF IMMUNIZATION RECORDS