ST. PAUL LUTHERAN SCHOOL

MEDICAL STATEMENT

TO BE COMPLETED BY PHYSICIAN

PLEASE NOTE: *AN UP-TO-DATE COPY OF YOUR CHILD'S IMMUNIZATION RECORD MUST BE RETURNED TO THE SCHOOL WITH THIS FORM.*

Child's Name: _____
(Last) (First) (Middle)

Date of Birth: _____ Place of Birth: _____

HEALTH CARE PROFESSIONAL'S STATEMENT: I have examined the above-named child within the past year and find that he/she is free of infectious and contagious disease and is physically and mentally able to take part in a school program.

Date of Examination: _____

_____ _____
Health Care Professional's Signature Date