HILL COUNTRY MONTESSORI SCHOOL

Student's Name:_____ Birth Date:_____
(Last) (First) (mm/dd/yyyy)

Address:_____
(Street) (City) (Zip)

Parent's Names:_____

THE FOLLOWING SECTION MUST BE COMPLETED AND SIGNED BY PHYSICIAN

Immunization Schedule: Please attach documentation of vaccines administered that includes the signature or stamp of the physician or his/her designee, or public health personnel. Documentation for immunizations must include child's name and birth date, each immunization type, and date (month, day, and year) received.

FINDINGS AND RECOMMENDATIONS

The Examination revealed the following significant physical or emotional conditions:

_____

_____

The above was found to be free of communicable disease and otherwise physically and emotionally fit to attend school and to participate in the activities appropriate to the child.

If No, please provide explanation:

_____

_____

_____
(Physician's Name) (Telephone)

_____
(Address) (City) (State) (Zip)

X_____ _____
(Physician's Signature) (Date)