

**Physician Health Statement**

The following child has been examined within the past year and is physically able to take part in the Springwood Montessori School program.

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| --- | --- | --- | --- |
| Child’s Name |  |  | Date of Birth |
| Physician’s signature |  | \_ | Date |
| Name of Physician |  | Address | Phone Number |

\* I give consent for the facility to secure any and all necessary emergency medical care for my child.

Signature – Parent or Legal Guardian

# This form must be completed and returned within 5 days of enrollment.

**Authorized Persons to Pick Up or be the Alternative Contact for your child.**

**The same people can act for both designations.**

Name Address Relation to Child Telephone Number

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