

**Black Mountain Presbyterian Church  
Weekday School**

PO Box 39, Black Mountain, NC 28711  
Phone: 828-669-2725 Fax: 828-669-2727

**Physician's Statement**

**\* \* \* This form must be filled out completely by the health care professional. \* \* \***

This is to certify that \_\_\_\_\_ (child's name),

whose date of birth is \_\_\_\_\_, was examined by me on \_\_\_\_\_ (date of examination), and based on his/her medical history and physical condition at the time of this examination, is free from apparent communicable disease, and is in suitable condition for enrollment in a child daycare facility; and has had the immunizations required by the State Department of Health for infants and toddlers, or is to be exempted from these requirements for medical reasons.

Does this child have any physical condition that we should be aware of?

\_\_\_\_\_

Does this child require special attention, medication, or routines that may have to be taken into consideration in planning for his/her time at school?

\_\_\_\_\_

\_\_\_\_\_

In your opinion, is this child physically and emotionally able to participate in a preschool program?

\_\_\_\_\_yes \_\_\_\_\_no

**Please provide child's immunization record** and any explanation, if needed, concerning any variations in the immunization schedule. Each child must be up to date with the immunizations recommended by the NC Department of Health.

DPT / DT / DTaP	1. _____	2. _____	3. _____	4. _____	5. _____
Polio IPV / OPV	1. _____	2. _____	3. _____	4. _____	
HIB	1. _____	2. _____	3. _____	4. _____	
Hepatitis B HBV	1. _____	2. _____	3. _____		
MMR	1. _____	2. _____			
Varicella	1. _____	2. _____			
Pevnar	1. _____	2. _____	3. _____	4. _____	

Physician's Signature/Office Name \_\_\_\_\_ Date \_\_\_\_\_