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.

_____ _____
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.

_____

<u>Authorized Persons to Pick Up or be the Alternative Contact</u> for your child.
The same people can act for both designations.

Name	Address	Relation to Child	Telephone Number