2019-2020

RIVERBEND MONTESSORI

HEALTH CARE PROVIDER STATEMENT (HCPS)

Child's Name:	Date of Birth:

HEALTH CARE PROFESSIONAL'S STATEMENT

☐ I have examined the above named child within the past year and find that he/she is able to take part in the day care program.

Signature:	Date:
Name of Health Care Professional:	
Address:	
Phone Number:	

- OR -

☐ A signed and dated copy of a Health Care Professional's statement is attached.

IMMUNIZATION RECORD

☐ I have attached a copy of the most recent immunization record.

VISION EXAM RESULTS

Right 20 /	Left 20 /	☐ Pass ☐ Fail
Signature:		**Date Signed:**

HEARING EXAM RESULTS

EAR	1000 Hz	2000 Hz	4000 Hz	Pass or Fail
RIGHT				☐ Pass ☐ Fail
LEFT				☐ Pass ☐ Fail
Signature:				**Date Signed:**

Parent's Signature:	Date: