

**MUST BE COMPLETED BY THE PHYSICIAN**

Name of Child: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Please attach a copy of this child's most current shot record or a notarized Affidavit of Exemption.  
The exemption form may be applied for from the Texas State Government website.

Allergies:  Yes  No

If yes, explain: \_\_\_\_\_

Does this child have any other medical conditions that should be mentioned (such as asthma, hay fever, etc.)?  
 Yes  No

If yes, explain: \_\_\_\_\_

**DOCTOR'S STATEMENT**

I have examined this child within the past year and find he/she is physically able to take part in preschool.

\_\_\_\_\_  
Physician's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Physician's Name

\_\_\_\_\_  
Physician's Phone Number

\_\_\_\_\_  
Address

\_\_\_\_\_  
City, Zip