Office Use Only

Checked _____

**Holy Covenant Child Development Center**

Physician's Statement

Child's Name: _____ Birth Date: _____

This form must be completed by your child's physician and include the physician's address and phone number. **It must be signed after June 1, 2020.**

**IMMUNIZATIONS:** Please attach your child's immunization record verified by your doctor or a health professional. Your child must have an up to date immunization record in order to attend our program. **We do not accept the affidavit from the State of Texas. We do not accept children on a delayed schedule.**

**TO THE PHYSICIAN:**

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

Doctor's Name: _____

Address: _____ Zip: _____

Telephone: _____

**DOCTOR'S SIGNATURE: _____DATE**: _____

**PARENT/ GUARDIAN SIGNATURE: _____DATE: _____**