Hope Rising Preschool

2020-2021 Doctor's Statement

Child's full name _____ Birth date _____

Physician's address _____ City _____ State _____ Zip _____

I have examined this child within the past 12 months, and find that he/she is physically able to take part in all activities at Hope Rising Preschool.

Physician's name	Physician's signature	Date
_____	_____	_____

Hearing screening Required for 4 years and up

	1000 Hz	2000 Hz	4000 Hz	
Left	_____	_____	_____	Pass ☐ Fail ☐
Right	_____	_____	_____	Pass ☐ Fail ☐

Physician's name	Physician's signature	Date
_____	_____	_____

Vision screening Required for 4 years and up

Left _____/20_____ Right _____/20_____

Physician's name	Physician's signature	Date
_____	_____	_____

This form must be signed or stamped and dated by the child's physician for all children enrolled at Hope Rising,