

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,