

Dental Care Provider: _____ Name

_____ Street Address City, State, Zip Telephone

Health Insurance Provider: _____

Certificate of Immunization: Yes No N/A Please explain: _____

My child has the following health conditions such as allergies, asthma, diabetes, epilepsy, etc., and/or takes the following medications on a regular basis:

Additional Comments: _____

I certify that to the best of my knowledge _____ Child's Name

_____ is in good mental and physical health and able to participate in the child care program at

_____ Name of Child Care Facility

Signature: _____ Date: _____
Parent or Guardian

Signature: _____ Date: _____
Director/Operator/Staff Designee