HEALTH REQUIREMENTS FORM

Name of Child:	**Date of Birth**:

☐ **HEALTH-CARE PROFESSIONAL'S STATEMENT:** I have examined the above named child within the past year and find that he / she is able to take part in the day care program.

_____ _____

Health Care Professional's Signature **Date**

Name of Health Care Professional: **Please Print**

Address of Health Care Professional:

4 Year Old Vision & Hearing Screening

Required for Children **4** years or older ***(If child Fails testing or is uncooperative, a re-test date must be noted)***

VISION	R 20/ _____	L 20/ _____	☐ **PASS** ☐ **FAIL**
SIGNATURE _____		**DATE** _____ **Re-test Date:** _____	

HEARING	**1000 Hz**	**2000 Hz**	**4000 Hz**	☐ **PASS** ☐ **FAIL**
R				
L				
SIGNATURE _____		**DATE** _____ **Re-test Date:** _____		

_____ _____

Signature – Parent or Legal Guardian Date