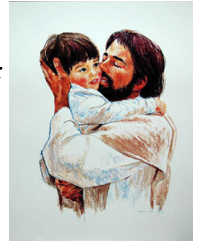

PHYSICAL EXAMINATION FORM

Zion Lutheran Child Care Center

N48 W18700 Lisbon Road
Menomonee Falls, WI 53051
262-781-6719



DATE OF PHYSICAL EXAMINATION: _____

CHILD'S FULL NAME: _____ BIRTHDAY: _____

ADDRESS: _____

CITY: _____ ZIP: _____ PHONE# _____

CHILD'S HEIGHT: _____ CHILD'S WEIGHT: _____

INSTRUCTIONS FOR FEEDING AND CARE OF CHILD WITH SPECIAL PROBLEMS, INCLUDING ALLERGIES-SPECIFY:

IMMUNIZATION(S) NOT TO BE ADMINISTERED TO CHILD DUE TO MEDICAL REASON(S)-SPECIFY:

AUTHORIZATION

I certify that I have examined the above child on this date and that he/she is able to participate in child care activities.

Examining Physician's name (please print)

Examining Physician's signature

NAME AND ADDRESS OF MEDICAL CLINIC:
