HEALTH REQUIREMENTS

A copy of an immunization record signed and stamped by a physician or health professional is required.

ADMISSION REQUIREMENT FOR ALL STUDENTS:

Child's Name: ________________________________ DOB:____________________

Physician Statement

Physician Statement: I have examined the above-named child within the past year and find that he/she is physically able to take part in the Bright Beginnings Early Learning Program. I also certify that this child's immunizations are current and up to date.

Food Allergies: **______No food allergy is present at this time**
______Diagnosed food allergy see Emergency Plan

___________________________________ ___________________________
Physician's Signature Date

___________________________________ ___________________________
Physician's Printed Name Physician's Phone Number

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