



# PHYSICIAN'S RELEASE

Physician's Name: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Phone 1 #: \_\_\_\_\_ Phone 2 #: \_\_\_\_\_

*I have examined \_\_\_\_\_ within the past twelve (12) months and have determined that they are healthy to participate in a preschool program.*

\_\_\_\_\_  
Physician's Signature

\_\_\_\_\_  
Date