St. Peter
Church & Preschool

MEDICAL FORM

ST PETER PRESCHOOL
15701 CLEVELAND GIBBS ROAD
ROANOKE, TX 76262

Health Care Professional Name: _____

Office Address: _____

City: _____ State: _____ Zip _____

Phone: (Include Area Code) _____

I have examined (Student's Name) _____
and find him/her to be able to take part in the child-care program of St Peter Pre-School

☐ With no exceptions

☐ With the following exceptions: _____

_____

_____

_____ _____
Health Care Professional's Signature Date