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 Preschool

❒ With no exceptions

❒ With the following exceptions: _____________________________________

(Required by Texas Dept. of State Health Services for <u>children 4yrs. and up</u> attending private or public school)

Hearing Screening _________________________________

Vision Screening __________________________________

____ ____________________
Health Care Professional's Signature Date

Must turn in **Up-to-date Immunization Records** by the first day of school.