



**MEDICAL DECLARATION STATEMENT
FOR SCHOOL-AGE CHILD CARE**

Ora Welch, M.Ed.
President / CEO
Mary M. Knapp
Chairperson

Child's Name _____

Date of Birth _____ Grade in September _____

Is your child under any medical/physical restrictions? ___Yes ___No

Asthma Hearing Loss Diabetes Convulsions Other:

Is your child taking any medication? ___Yes ___No
If yes, please list _____

Has your child been under a doctor's care or hospitalized within the last three years.
___Yes ___No If yes, please explain _____

Is your child allergic to any medications/foods/insect stings? ___Yes ___No
If yes, please explain: _____

Family Doctor's Name: _____
Address: _____
Telephone Number : _____

As a parent/guardian of the above participating child,
I certify that he/she is in good physical health, has no
special needs, and may participate in all of the activities
of the Center's program, except as noted above

Parent / Guardian Signature: _____

Date: _____