PHYSICIAN FORM

DIRECTOR, KAREN OTTO
860 KELLER SMITHFIELD RD, KELLER, TX 76248 | 817-431-3185 | WWW.THESUMMIT.SCHOOL

Child's Name: Birthdate:

Please **ATTACH** a copy of your child's most current immunization record. **Parent Initials**:_____

ADMISSION REQUIREMENT: If your child does not attend pre-kindergarten away from The Summit Preschool of The Mount, we need one of the following: **(CHOOSE ONE)**

Health-Care Professional's Statement: *I have examined above named child within the past year and find that he/she is able to take part in The Summit Preschool of The Mount*

Health-Care Professional's Signature **Date**

Name and Address of Health Care Professional:

___ A signed and dated copy of a health care professional's statement is attached.

Name and Address of Health Care Professional:

___ My child has been examined within the past year by a health care professional and is able to participate in The Summit Preschool program.

Within 12 months of admission I will obtain a health care professional' s signed statement and will submit it.

Name and Address of Health Care Professional:

Parent Signature and Date

HEARING/VISION - *REQUIRMENT 4 YEARS ONLY*
Please have doctor fill out results OR attach a copy of results. WE MUST HAVE THE RESULTS.

Vision	Right 20/_____	Left 20/_____
	Pass	Fail

Physician Signature/Date _____

Hearing	1000 HZ	2000 HZ	4000 HZ
Right			
Left			
		Pass	Fail

Physician Signature/Date _____

Parent Signature and Date