Physician's Health Examination

To be completed by child's physician prior to attending at the Ark

Child's Name: _____ Birthdate: _____/_____/_____ Sex: Male/Female
Month Date Year (Please circle)

Please check "no" or "yes." If "yes," specify recommendations.

		No	Yes
1.	Are there any hearing or speech problems?		
2.	Are there any physical or developmental problems which will require modification to school activities?		
3.	Is the child subject to conditions which make for classroom emergencies? Example (circle): epilepsy, diabetes, fainting, allergies, etc.		
4.	Are there any mental or emotional conditions for which the child should remain under supervision?		
5.	Does the child have any other medical condition with which the school should be concerned?		
6.	Is the child currently taking any long-term medications?		

Physician's recommendations to the Ark: _____

_____

Please submit a copy of the child's immunization record **OR** complete the form below. If medical or religious exemption from immunizations is applicable, dated exemption must be attached.

DTaP	1.	2.	3.	4.	5.
HIB	1.	2.	3.	4.	
Hep B	1.	2.	3.		
IPV	1.	2.	3.	4.	
MMR	1.	2.			
Varicella	1.				
Prevnar	1.	2.	3.	4.	
Hep A	1.	2.			
COVID	1.	2.	3.		
Other:					

Physician's Statement

(Child's full name) _____ has no previous history of illnesses and/or injuries that would interfere with participating in the Ark programs. This child has been examined by me, and is both physically and mentally able to participate in the Ark's programs.

Physician's signature: _____ Phone: _____

Physician's full name: _____ Date: _____

Address: _____

The Ark has the right to request a re-examination by a child's physician if a significant change in the child's health or behavior is noticed. Physician's office may fax to the **Ark at 505-663-0089**.

Form 7/30/2022