MEDICAL FORM
(FOR HOUSEHOLD MEMBERS UNDER AGE 18)

CHILD 1

NAME: ______________________________

DATE OF BIRTH: ____________________

FREE OF COMMUNICABLE
AND CONTAGIOUS DISEASES: ________________________

CHILD 2

NAME: ______________________________

DATE OF BIRTH: ____________________

FREE OF COMMUNICABLE
AND CONTAGIOUS DISEASES: ________________________

CHILD 3

NAME: ______________________________

DATE OF BIRTH: ____________________

FREE OF COMMUNICABLE
AND CONTAGIOUS DISEASES: ________________________

In my opinion, this individual is physically, psychologically and emotionally healthy.

Comments:____
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______________________________	______________________________
Physician's Signature	Printed Name
______________________________	______________________________
Date	Address