Grapevine Christian School
TEACH • LOVE • INSPIRE

PHYSICIAN'S HEALTH STATEMENT

Child's Full Name	Child's Date of Birth

PHYSICIAN'S HEALTH STATEMENT

I have examined the above named child within the past year and find that he / she is able to take part in the day care program.

Physician's Name (Printed)	Address	Phone #
	City/State/Zip	

_____ _____

Physician's Signature **Date**

HEARING AND VISION

Hearing and vision screening is to be completed for students who are **four years of age and above by September 1st**. If this area is not completed, GCS will screen students during the school year.

VISION	R 20/ _____	L 20/ _____	☐ PASS ☐ FAIL
SIGNATURE _____		DATE _____	

HEARING	**1000 Hz**	**2000 Hz**	**4000 Hz**	☐ PASS ☐ FAIL
R				
L				
SIGNATURE _____		DATE _____		