

Lamb of God Early Childhood Ministry
Physician's Statement
1401 Cross Timbers Road, Flower Mound, TX 75028
972-539-0055 Fax: 972-539-8194

Physician's Examination

To be completed by physician:

Child's Name: _____

Date of Exam: _____ Birthdate: _____

Hearing Screening: _____ Vision Screening: _____
(required by Texas Dept. of State Health Services for children 4yrs. and up attending private or public school)

Other Tests: _____

Allergies or Medical Conditions: _____

**I have examined the child named above and find that he/she IS/IS NOT able to participate in a preschool program.
I have examined the immunization record and attest that it is a true and accurate listing.**

Physician's Signature: _____ Date: _____

Physician's Address _____ Phone: _____

Please attach a current copy of the child's immunization record to this form.