MUMP

HEALTH CERTIFICATE

Name of child ____

School to which applying ______MEMORIAL UNITED METHODIST PRESCHOOL________

Is this child up to date with his shots? ______________________________

Is there any reason this child cannot participate in normal activities? ______________

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Are there any health conditions that should be known by the school? ______________

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Date ____________________

Signature of the physician ____________________________________

Physician's printed name ____________________________________