



**TO BE COMPLETED BY FAMILY PHYSICIAN**  
for any child under 18 years of age

Name and birth date of child:

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Child's Height and Weight:

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Is this child current on all immunizations?

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Is this child free of communicable and contagious diseases?

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Please comment on the health and development of this child:

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Please comment on the level of care that this child has received in the home:

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Date: \_\_\_\_\_

Physician's Signature: \_\_\_\_\_

Physician's Printed Name: \_\_\_\_\_

Address: \_\_\_\_\_

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