Little Acorns Child Development Center

Medical Authorization for Participation

Child's Name _____ Birthdate _____

I certify that I have examined the above named child within the past 12 months. This child is healthy and capable of participating in a preschool program.

Physician's Signature _____ Date _____

PreK and TK Only

Vision	Right 20/___		Left 20/___	Pass ___	Fail ___
Hearing	1000 HZ	2000 HZ	4000 HZ	Pass ___	Fail ___

Immunization Record

Please attach the most recent copy of your child's immunization record. Please be sure your child's first and last name, and date of birth are on the record.

Little Acorns Child Development Center
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