

St. Paul's Preparatory Academy
Physician's Statement

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Child's Name _____ Date of Birth _____

Date of Last Examination _____

I have examined the child listed above within the past year and find that he/she is physically and mentally able to take part in St. Paul's Preparatory Academy's program.

Yes _____ No _____

If no, please explain _____

Can this child participate in the program without special care related to allergies, special diet, restriction of activities or any other chronic condition?

Yes _____ No _____

If no, please explain _____

Is this child free of infectious or contagious disease?

Yes _____ No _____

If no, please explain _____

Physician's Signature

Date

Physician's Name Printed

St. Paul's Preparatory Academy
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