



## Wellness Statement

**To be completed by Child's Physician:**

Child's Name \_\_\_\_\_

Physician's Name \_\_\_\_\_

Physician's Address \_\_\_\_\_

\_\_\_\_\_

Physician's Phone Number \_\_\_\_\_

I, the undersigned, have examined the above-mentioned child in the last 12 months, and have found the child to be in good health and able to participate in all normal activities, including a day care program.

Date of most recent exam: \_\_\_\_\_

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

\_\_\_\_\_  
Date

Vaccination records will be kept on file year to year. Please be advised that it is your responsibility to inform the school in writing of any new medical updates.

**This form can be faxed to the Austin International School at (512) 219-5201.**