



Healthcare Professional's Statement

If your child does not attend pre kindergarten or school away from the childcare facility, one of the following must be completed prior to your child's first day at the facility.

Operation Name: *AstroTots Academy & Daycare*

Operation Number: 1653528

Address: 2941 S. Precinct Line Rd, Fort Worth, TX 76118

Phone Number: [817] 537-2941

Fax Number: [817] 590-8842; ATTN: Director

Email: director@astrototsacademy.com

Please check only **one [1]** option:

_____ A signed and dated copy of the Healthcare Professional's Statement: [below]

HEALTHCARE PROFESSIONAL'S STATEMENT: I have examined the above named child within the past year and find that he/she is able to take part in the daycare program.

_____ / ____ / _____ [] Male or [] Female
[Child's Full Name] [Date of Birth] [Age]

Physical Exam:

[] Normal [] Abnormal - *see explanation of significant health concerns*

Significant Health Concerns:

[] None [] Seizures [] Diabetes [] Asthma [] Hospitalizations
[] Sever Allergies [] Developmental Delays [] Other

Explain Significant Health Concerns: _____

Surgery, Accidents, Illnesses, Chronic or Handicapping Problems: _____

Current Medications or Special Diets: _____

Physical findings [*Please include vision and hearing screen for children 4 or older***]: _____

*****Please attach a copy of the child's up-to-date immunization record to meet Texas State Childcare licensing criteria*****

[Healthcare Professional's Signature]

____/____/_____
[Date]

[Name of Healthcare Professional]

[Address of Healthcare Professional]

[City]

[State]

[Zip Code]

VISION:	R 20/_____	L 20/_____	[] Pass	[] Fail
HEARING:	1000 Hz	2000 Hz	4000 Hz	
	L _____	_____	_____	[] Pass [] Fail
	H _____	_____	_____	

_____ Medical diagnosis and treatment conflict with the tenets and practices of a recognized religious organization, which I adhere to or am a member of. I have attached a signed and dated affidavit stating this.

[Signature of Parent or Guardian]

____/____/_____
[Date]