Eanes Child Development
Health Care Provider Statement

Child's Name: _____ Date of Birth: _____

I have examined the above-named child within the past year and find that he or she is able to participate in the Eanes ISD Child Development Program.

Notes:

Physician & Practice Name: _____

Address: _____

Phone Number: _____

Physician Signature: _____ Date: _____

*This form must be completed every 12 months and returned to the Eanes Child Development Center. You may return to the parent requesting or faxed to the Eanes CDC @ 512-732-9148.