Get Well Care 4 Kidz – Pediatrician Health Statement

This form must be completed by the child's licensed pediatric healthcare provider prior to entry.

Child Information

Child's Full Name: _____

Date of Birth: _____ **Age:** _____

Parent/Guardian Name: _____

Phone Number: _____

Healthcare Provider Information

Pediatrician / Healthcare Provider Name: _____

Practice / Clinic Name: _____

Address: _____

Phone: _____ **Fax:** _____

License Number: _____

Health Clearance Statement

I have examined the above-named child and certify that, to the best of my knowledge:

☐ The child is medically stable and **approved to attend Get Well Care 4 Kidz**.

☐ The child **requires sick care monitoring** but does not require hospitalization or continuous one-on-one medical supervision.

☐ The child **does not exhibit symptoms requiring exclusion**, such as uncontrolled fever, respiratory distress, altered mental status, or other conditions requiring emergency care.

Current Diagnosis / Reason for Sick Care (if applicable)

Medications

☐ No medications required during care hours

☐ Medications required (attach medication authorization form):

Medication Name(s): _____

Dosage / Frequency: _____

Allergies

☐ No known allergies

☐ Allergies (food, medication, environmental):

Special Instructions or Restrictions (e.g., activity limitations, hydration needs, dietary restrictions)

Clearance Duration

This health statement is valid for:

☐ Today only

☐ Up to _____ days (not to exceed provider recommendation)

Provider Attestation

I certify that the information provided above is accurate and that this child is appropriate for participation in Get Well Care 4 Kidz Sick Care Day services.

Provider Signature: _____

Printed Name: _____

Date: _____

For Office Use Only

Date Received: _____

Reviewed By: _____ **Initials:** _____

Approved for Entry: ☐ Yes ☐ No