Healthcare Professional Statement

Memorial Lutheran School Student

Child's Name_____

Child's Birthdate_____/_____/_____

I have examined the above named child within the past year and find that he/she is able to participate in your school's program.

_____

Physician or Healthcare Professional Signature Date

I have provided the school a copy of my child's most updated immunizations.

_____

Parent Signature Date

Memorial Lutheran School
5800 Westheimer Rd
Houston, TX 77057

713-782-4022
713-975-1684 Fax