

**Lockhart ISD Cub House Child Development Center
Health Care Professional Verification of Care Statement**

Child's Name _____ **Date of Birth** ___/___/___

The Texas Department of Family and Protective Services requires verification of ongoing health care for children entering day care. Please read and complete the following statement and return this form to the child's parent.

I, _____, confirm the child named above has, within the past 12 months, been examined by me or one of my fellow physicians at this practice. In addition, I confirm he/she is physically able to participate in the programs and activities provided by Lockhart ISD Cub House Child Development Center.

Physician's Signature _____
Date Signed

Address _____
Phone Number

Please add any exceptions or precautions regarding the child's participation:

