



Sunshine Academy

MEDICAL DOCUMENTATION FOR ILLNESSES

Date: _____

Child's Name: _____

Child's Date of Birth: _____

Physician's Name: _____

Physician's Address: _____

Physician's Medical License Number: _____

Child Was Examined Due to the Following Symptoms: _____

Date Child Was Examined: _____

Medical Diagnosis of the Illness: _____

Likelihood to Transmit the Illness to Other Children in a Group Setting (circle one):

High

Medium

Low

None

Physician's Signature _____ Date: _____