

Well Child Exam Verification

TO BE COMPLETED BY PARENT:

Child's Name _____ Birth Date ____ / ____ / ____

Medical Clinic/Provider's Name _____

Medical Clinic Address _____

Street Address

City _____ State _____ Zip code _____

Medical Clinic's Phone Number _____

TO BE COMPLETED BY MEDICAL PROVIDER:

I have completed a well child exam on the patient named above, and hereby state that this child is approved for participation in the physical activity program of Indian Health Care Resource Center of Tulsa.

Name

Date

**PARENTS: PLEASE ATTACH THIS FORM TO THE
SUMMER CAMP ENROLLMENT FORM WHEN YOU
SEND IT IN.**

THANK YOU VERY MUCH!