MEDICAL REPORT & DIAGNOSIS VERIFICATION

Name of child _____ D.O.B._____

Name of Parent/Guardian_____ Phone #_____

Address of Parent/Guardian_____

Medical Examination & Verification (This examination must be completed and signed by a licensed physician or a certified nurse practitioner.)

I, _____, certify that on _____
name of physician (please print) date of appointment

I personally examined _____, who is 18 years old or younger.
patient's first and last name (please print)

On the basis of my examination and all information provided to me, I confirm that he/she is currently

diagnosed with _____.
current diagnosis

Name of authorized examiner/title (please print) _____

Name of Medical Facility_____

Address of Medical Facility_____ **Phone #**_____

Signature of authorized examiner _____**Date**_____