MEDICAL REPORT & DIAGNOSIS VERIFICATION

Name of child ____ D.O.B.__________________________

Name of Parent/Guardian_____________________________________ Phone #_________________________

Address of Parent/Guardian____

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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**_______________________