Verified Doctor Check

Parent/Guardian Name: _____ Date of First Visit: _____

Child's Name: _____

Doctor's Name: _____

Address: _____

City, State, Zip Code: _____

Phone Number: _____

Doctor Check [ ] The above doctor has examined my child within the past year and my child is able to participate in Annie's Place at Parkland.

Within 12 months from my child's first visit to Annie's Place, I will submit the Professional Health Care Statement.

_____ _____

Parent Signature Date