

**SOUTHMINSTER SCHOOL**

4200 Cartwright Road  
Missouri City, Texas 77459  
281-261-8872  
Fax# 281-499-4430



**Physician's Statement**

Student \_\_\_\_\_ Date of Birth \_\_\_\_\_

**I certify that the above named child is free of communicable disease, and is physically and mentally able to participate in the school program.**

Physician's signature \_\_\_\_\_ Date \_\_\_\_\_  
(or stamp)

Physician's address \_\_\_\_\_ Phone \_\_\_\_\_

**Please include any vision and or hearing testing completed in your office.**

**Please include updated immunization records**