

KOALA KARE CHILDCARE CENTER & PRE-SCHOOL PROGRAM  
PHYSICIAN RETURN TO CHILDCARE PERMISSION (FORM I)

CHILD'S  
NAME \_\_\_\_\_ DOB/AGE \_\_\_\_\_

DIAGNOSIS \_\_\_\_\_

DATE TO RETURN TO  
CHILDCARE \_\_\_\_\_

SPECIAL  
INSTRUCTIONS \_\_\_\_\_

SIGNATURE OF  
EXAMINER \_\_\_\_\_ DATE \_\_\_\_\_