Name	Class	Day(s)/ Time(s)
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		f.	IVING SCIENCE	CENTER			
	201	7-2018 Na	ture School		tement		
Child's Name				Phone _			
	Last	First	Mia				
Address			City		State	Zip _	
Date of Birth _			Aller	gies			
Medical Insura	nce Carrier						
Physician's Na	me			Phone _			
Address			City		State	Zip _	
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		omy one op.					
			Statement: I have is physically able t				
	Health Care Pro	ofessional's Signati	ure	Date			
		_					
		dated copy of	a health care prof	essional's statem	ent is attac	ched.	
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Physician's Signature

Updater's Signature

Date

Date