WESTWOOD MOTHER'S DAY OUT
8200 Old Keene Mill Road
Springfield, VA 22152
703-455-6360

PARENT HEALTH RECORD

I certify that ______________________________is apparently free from tuberculosis and is free from any disability which would prevent him or her from caring for children.

Physician's Signature:

____

Address:

____

____

Phone: Date:

_______________ ________

Negative chest x-ray or negative tuberculin test result. Test must be given biennially.

Date ___________

(Please enclose card from Health Center or statement from physician giving results.)