Rising Star Academy
A PRIVATE PRESCHOOL
Shooting for the Stars

I hereby authorize Dr. _____to release shot records, hearing & vision, and/or physician's statement for my child_____.

NAME OF SCHOOL: RISING STAR ACADEMY
SCHOOL ADDRESS: 920 SOUTH PEEK ROAD
KATY, TX 77450
281-391-5437 TELEPHONE
281-574-8430 FAX

PLEASE SEND: ☐ **SHOT RECORDS** ☐ **PHYSICIAN'S STATEMENT** ☐ **HEARING & VISION**

_____ _____
Parent's Signature **Date**

_____ _____
Doctor's Phone Number **Doctor's Fax Number**

Physician's Statement:

This child has been examined within the past year and he/she is physically able to take part in the normal activities of a child care program.

_____ _____
Physician's Signature **Date**

****Please fax or email back to Rising Star Academy at the following:**

info@risingstar-academy.com

Fax 281-574-8430