KENDALL DEMONSTRATION ELEMENTARY SCHOOL

STUDENT'S NAME (PRINT) _____ **DATE OF BIRTH** _____

Left Arm: _____ Right Arm: _____

Date Given: ____/____/____/

Date Read: ____/____/____/

Induration: _____mm

_____
Physician or provider's signature

_____
Physician printed name

_____
Address

_____
Phone Number

I give permission for the Kendall School nurse and my child's primary care physician,

_____,
Name of Physician

to share information relating to this form.

_____
Parent/Guardian's Signature

Date: ____/____/____/