

## Medical Report of Child in Day Care

To Be Completed By Physician, Physician's Assistant or Nurse Practitioner

Name _____	Date of Birth _____ / /	Date of Exam _____ / /
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### IMMUNIZATIONS

If one or more of the required medical immunizations is deemed detrimental to this child's health, attach certificate specifying which immunization(s) and complete and sign medical exemption statement on back of form.

	Include All Dates				
	1st	2nd	3rd	Booster	Booster
DPT	/ /	/ /	/ /	/ /	/ /
ORAL POLIO	/ /	/ /	/ /	/ /	/ /
Hib(conjugate preferred)	/ /	/ /	/ /	4th / /	
Hepatitis B	/ /	/ /	/ /		
MMR	/ /	/ /			

Other Immunizations	
Type	Date
	/ /
Type	Date
	/ /
Type	Date
	/ /

### TESTS

<p style="text-align: center;"><b>Tuberculin Test</b></p> <p>_____ / ____ / ____ Date</p> <table style="margin-left: auto; margin-right: auto;"> <tr> <td style="text-align: center;">Pos <input type="checkbox"/></td> <td style="text-align: center;">Neg <input type="checkbox"/></td> </tr> <tr> <td colspan="2" style="text-align: center;">Results</td> </tr> </table> <table style="margin-left: auto; margin-right: auto;"> <tr> <td style="text-align: center;">Tine <input type="checkbox"/></td> <td style="text-align: center;">Mantoux <input type="checkbox"/></td> </tr> <tr> <td colspan="2" style="text-align: center;">Specify</td> </tr> </table> <p>If <b>positive</b>, attach physician's statement documenting treatment and follow-up.</p>	Pos <input type="checkbox"/>	Neg <input type="checkbox"/>	Results		Tine <input type="checkbox"/>	Mantoux <input type="checkbox"/>	Specify		<p style="text-align: center;"><b>Lead Screening</b></p> <p>_____ / ____ / ____ Date</p> <p>Attach statement of lead screening.</p>
Pos <input type="checkbox"/>	Neg <input type="checkbox"/>								
Results									
Tine <input type="checkbox"/>	Mantoux <input type="checkbox"/>								
Specify									

### HEALTH SPECIFICS

<input type="checkbox"/> Yes <input type="checkbox"/> No    Are there allergies? (Specify) _____ <input type="checkbox"/> Yes <input type="checkbox"/> No    Is medication regularly taken? (Specify drug and condition) _____ <input type="checkbox"/> Yes <input type="checkbox"/> No    Is a special diet required? (Specify diet and condition) _____ <input type="checkbox"/> Yes <input type="checkbox"/> No    Are there any hearing, visual or dental conditions requiring special attention? <input type="checkbox"/> Yes <input type="checkbox"/> No    Are there any medical or developmental conditions requiring special attention?	<p style="text-align: center;"><b>Comments:</b></p> <hr/> <hr/> <hr/> <hr/>
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### SUMMARY OF PHYSICAL EXAM (including special recommendations to Day Care Provider)

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On the basis of my findings as indicated above and on my knowledge of the above named child, I find that: (s)he is free from contagious and communicable disease  Yes  No and is able to participate in day care  Yes  No

Signature of Examiner _____	Address _____
Name (please print) _____	City, State, Zip _____
Title _____	Phone (____) _____ / _____ / _____ Date _____