

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						Other Immunizations	
DPT	1st	2nd	3rd	Booster	Booster	Type	Date
	/ /	/ /	/ /	/ /	/ /		/ /
ORAL POLIO	1st	2nd	3rd	Booster	Booster	Type	Date
	/ /	/ /	/ /	/ /	/ /		/ /
Hib(conjugate preferred)	1st	2nd	3rd	4th		Type	Date
	/ /	/ /	/ /	/ /			/ /
Hepatitis B	1st	2nd	3rd			Type	Date
	/ /	/ /	/ /				/ /
MMR	1st	2nd				Type	Date
	/ /	/ /					/ /

TESTS

<p style="text-align: center;">Tuberculin Test</p> <table style="width: 100%; text-align: center;"> <tr> <td>Pos</td> <td>Neg</td> <td>Tine</td> <td>Mantoux</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td colspan="2">Results</td> <td colspan="2">Specify</td> </tr> </table> <p>_____/_____/_____ Date</p> <p>If positive, attach physician's statement documenting treatment and follow-up.</p>	Pos	Neg	Tine	Mantoux	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Results		Specify		<p style="text-align: center;">Lead Screening</p> <p style="text-align: center;">_____/_____/_____ Date</p> <p>Attach statement of lead screening.</p>
Pos	Neg	Tine	Mantoux										
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>										
Results		Specify											

HEALTH SPECIFICS	Comments:
<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?	

SUMMARY OF PHYSICAL EXAM (including special recommendations to Day Care Provider)

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
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