

## 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 |
|------|---------------|--------------|

### 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

|                          |            |            |            |                |                |
|--------------------------|------------|------------|------------|----------------|----------------|
| DPT                      | 1st<br>/ / | 2nd<br>/ / | 3rd<br>/ / | Booster<br>/ / | Booster<br>/ / |
| ORAL POLIO               | 1st<br>/ / | 2nd<br>/ / | 3rd<br>/ / | Booster<br>/ / | Booster<br>/ / |
| Hib(conjugate preferred) | 1st<br>/ / | 2nd<br>/ / | 3rd<br>/ / | 4th<br>/ /     |                |
| Hepatitis B              | 1st<br>/ / | 2nd<br>/ / | 3rd<br>/ / |                |                |
| MMR                      | 1st<br>/ / | 2nd<br>/ / |            |                |                |

#### Other Immunizations

|      |             |
|------|-------------|
| Type | Date<br>/ / |
| Type | Date<br>/ / |
| Type | Date<br>/ / |

### TESTS

#### Tuberculin Test

\_\_\_\_/\_\_\_\_/\_\_\_\_  
Date

|                                  |                                     |
|----------------------------------|-------------------------------------|
| Pos<br><input type="checkbox"/>  | Neg<br><input type="checkbox"/>     |
| Results                          |                                     |
| Tine<br><input type="checkbox"/> | Mantoux<br><input type="checkbox"/> |
| Specify                          |                                     |

#### Lead Screening

\_\_\_\_/\_\_\_\_/\_\_\_\_  
Date

If positive, attach physician's statement documenting treatment and follow-up.

Attach statement of lead screening.

#### HEALTH SPECIFICS

#### Comments:

- Yes  No    Are there allergies? (Specify)
- Yes  No    Is medication regularly taken? (Specify drug and condition)
- Yes  No    Is a special diet required? (Specify diet and condition)
- Yes  No    Are there any hearing, visual or dental conditions requiring special attention?
- Yes  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

Title

Phone

Date