

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 the second page of form.

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

Tests

<p style="text-align: center;">Tuberculin Test</p> <table style="width: 100%; text-align: center;"> <tr> <td>Pos</td> <td>Neg</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td colspan="2">Results</td> </tr> </table> <p>____ / ____ / ____ Date</p>	Pos	Neg	<input type="checkbox"/>	<input type="checkbox"/>	Results		<table style="width: 100%; text-align: center;"> <tr> <td>Tine</td> <td>Mantoux</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td colspan="2">Specify</td> </tr> </table>	Tine	Mantoux	<input type="checkbox"/>	<input type="checkbox"/>	Specify		<p style="text-align: center;">Lead Screening</p> <p style="text-align: center;">____ / ____ / ____ Date</p> <p style="text-align: center;">Attach statement of lead screening.</p>
Pos	Neg													
<input type="checkbox"/>	<input type="checkbox"/>													
Results														
Tine	Mantoux													
<input type="checkbox"/>	<input type="checkbox"/>													
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? <small>(Specify drug and condition)</small>	
<input type="checkbox"/> Yes <input type="checkbox"/> No Is special diet required? <small>(Specify diet and condition)</small>	
<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
Title	Phone
	Date

Medical Exemptions

The physical condition of the above named child is such that immunization would endanger life or health.

Physician's Signature

Date

X

____ / ____ / ____