

Medical Report of Child In Day Care
To Be Completed By Physician, Physician's Assistant or Nurse Practitioner

Child 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	1 ST / /	2 ND / /	3 RD / /	Booster / /	Booster / /	Type	Date / /
ORAL POLIO	1 ST / /	2 ND / /	3 RD / /	Booster / /	Booster / /	Type	Date / /
Hib (conjugate preferred)	1 ST / /	2 ND / /	3 RD / /	4 TH / /		Type	Date / /
Hepatitis B	1 ST / /	2 ND / /	3 RD / /				
MMR	1 ST / /	2 ND / /					

TESTS

Tuberculin Test			Lead Screening		
Date ____/____/____ If positive attach Physicians statement documenting treatment & Follow up	POS <input type="checkbox"/>	NEG <input type="checkbox"/>	Tine <input type="checkbox"/>	Mantoux <input type="checkbox"/>	Date ____/____/____ Attach statement of Lead Screening
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 & condition)	
<input type="checkbox"/> Yes <input type="checkbox"/> No Is a special diet required? (Specify diet & 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 Providers)

On the basis of my findings as indicated 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 health

_____/_____/_____
 Physicians Signature Date