

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

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

### TESTS

<p style="text-align: center;"><b>Tuberculin Test</b></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> <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> <p>_____/_____/_____ Date</p>	Pos	Neg	<input type="checkbox"/>	<input type="checkbox"/>	Results		Tine	Mantoux	<input type="checkbox"/>	<input type="checkbox"/>	Specify		<p style="text-align: center;"><b>Lead Screening</b></p> <p style="text-align: center;">_____/_____/_____ Date</p> <p>Attach statement of lead screening.</p>
Pos	Neg												
<input type="checkbox"/>	<input type="checkbox"/>												
Results													
Tine	Mantoux												
<input type="checkbox"/>	<input type="checkbox"/>												
Specify													

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

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  _____ Name (please print)  _____ Title	_____ Address  _____ City, State, Zip  _____ Phone  _____ / _____ / _____ Date
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