



HEALTH CARE PROGRAM FOR CHILD CARE CENTERS CHILD CARE CENTER HEALTH RECORD

State Form 45877 (R3 / 10-02) / BCD 0054

CHILDCARE HEALTH SECTION
BUREAU OF CHILD DEVELOPMENT
DIVISION OF FAMILY AND CHILDREN

Name of child (<i>last, first</i>)	Date of birth	Admission date
Address (<i>number and street, city, state, ZIP code</i>)		
Child lives with (<i>relationship</i>)	Name	Telephone number

MEDICAL HISTORY			
Communicable Disease	Month / Year	Condition	Explain if present
Measles		Allergies:	
Rubella (German Measles)			
Chickenpox		Handicapping conditions:	
Mumps			
Scarlet Fever		Other:	
Whooping Cough			
Other: _____			

PHYSICAL EXAMINATION	
Date of exam	Age of child
Skin	Heart
Lymphnodes	Lungs
Eyes	Abdomen
Ears	Genitalia
Nasopharynx	Skeleton
Teeth and Mouth	Other:

Note any unusual findings:

Does this child have any health condition that would be hazardous either to the child or to other children in a group setting as a result of participation in normal activities (*including sports*)? Yes No If Yes, what modification of normal activities would be necessary to protect the child and the child's classmates:

Have you prescribed any medications or special routines which should be included in the center's plans for this child's activities? Explain:

Yes No

HISTORY OF IMMUNIZATIONS AND TEST (indicate month / day / year)

	1	2	3	4	5
DTP / DT / Td					

	1	2	3	4
Hib				

	1	2	3	4	5
IPV					

	1	2
Measles		

	1	2
Mumps		

	1	2
Rubella		

	1	2
Varicella		

	1	2	3	4
Pneumococcal (PCV)				

	1	2	3
HBV			

NOTE: To be considered adequately immunized, a child of age twenty-four months should have received four DTP inoculations, three polio inoculations, one inoculation against measles, mumps, and rubella, and at least 3 Hib vaccinations.

Name of physician completing form (<i>please print</i>)	Telephone number
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Signature of physician

ADDITIONAL NOTES AND INSTRUCTIONS