Medical Report of Child

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 / /	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 / /
Type	Date / /

TESTS

Tuberculin Test

____/____/____ Date

Pos ☐ Neg ☐ Results

Tine ☐ Mantoux ☐ Specify

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

Lead Screening

____/____/____ Date

Attach statement of lead screening.

HEALTH SPECIFICS

	Question	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)

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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 / /