# 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 |
|---|---|---|
| | / / | / / |

## 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

Results: Pos ☐ Neg ☐

Specify: Tine ☐ Mantoux ☐

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

**Lead Screening**

____/____/____ Date

Attach statement of lead screening.

| HEALTH SPECIFICS | | 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)**

*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**<br>The physical condition of the above named child is such that immunization would endanger life or health. | |
|---|---|
| Physician's Signature<br>X | Date<br>_____ / _____ / _____ |