

# PHYSICIAN'S REPORT—CHILD CARE CENTERS (CHILD'S PRE-ADMISSION HEALTH EVALUATION)



## PART A – PARENT'S CONSENT (TO BE COMPLETED BY PARENT)

\_\_\_\_\_, born \_\_\_\_\_ is being studied for readiness to enter  
(NAME OF CHILD) (BIRTH DATE)

\_\_\_\_\_. This Child Care Center/School provides a program which extends from \_\_\_\_\_ : \_\_\_\_\_  
(NAME OF CHILD CARE CENTER/SCHOOL)

a.m./p.m. to \_\_\_\_\_ a.m./p.m. , \_\_\_\_\_ days a week.

Please provide a report on above-named child using the form below. I hereby authorize release of medical information contained in this report to the above-named Child Care Center.

\_\_\_\_\_  
(SIGNATURE OF PARENT, GUARDIAN, OR CHILD'S AUTHORIZED REPRESENTATIVE)

\_\_\_\_\_  
(TODAY'S DATE)

## PART B – PHYSICIAN'S REPORT (TO BE COMPLETED BY PHYSICIAN)

Problems of which you should be aware:

Hearing: \_\_\_\_\_ Allergies: medicine: \_\_\_\_\_  
Vision: \_\_\_\_\_ Insect stings: \_\_\_\_\_  
Developmental: \_\_\_\_\_ Food: \_\_\_\_\_  
Language/Speech: \_\_\_\_\_ Asthma: \_\_\_\_\_  
Dental: \_\_\_\_\_  
Other (Include behavioral concerns): \_\_\_\_\_  
Comments/Explanations: \_\_\_\_\_

MEDICATION PRESCRIBED/SPECIAL ROUTINES/RESTRICTIONS FOR THIS CHILD: \_\_\_\_\_

### IMMUNIZATION HISTORY: (Fill out or enclose California Immunization Record, PM-298.)

VACCINE	DATE EACH DOSE WAS GIVEN				
	1st	2nd	3rd	4th	5th
POLIO (OPV OR IPV)	/ /	/ /	/ /	/ /	/ /
DTP/DTaP/ DT/Td (DIPHTHERIA, TETANUS AND [CELLULAR] PERTUSSIS OR TETANUS AND DIPHTHERIA ONLY)	/ /	/ /	/ /	/ /	/ /
M (MEASLES, MUMPS, AND RUBELLA)	/ /	/ /			
M (REQUIRED FOR CHILD CARE ONLY)	/ /	/ /	/ /	/ /	
IPV HIB MENINGITIS (HAEMOPHILUS B)	/ /	/ /	/ /	/ /	
HEPATITIS B	/ /	/ /	/ /		
VARICELLA (CHICKENPOX)	/ /	/ /	/ /		

#### SCREENING OF TB RISK FACTORS (listing on reverse side)

Risk factors not present; TB skin test not required.

Risk factors present; Mantoux TB skin test performed (unless previous positive skin test documented).

\_\_\_ Communicable TB disease not present.

I have \_\_\_\_\_ have not \_\_\_\_\_ reviewed the above information with the parent/guardian.

Physician: \_\_\_\_\_ Date of Physical Exam: \_\_\_\_\_  
Address: \_\_\_\_\_ Date This Form Completed: \_\_\_\_\_  
Telephone: \_\_\_\_\_ Signature \_\_\_\_\_

Physician Physician's Assistant Nurse Practitioner