

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 [ACELLULAR] PERTUSSIS OR TETANUS AND DIPHTHERIA ONLY)	/ /		/ /		/ /		/ /		/ /	
MMR	(MEASLES, MUMPS, AND RUBELLA)	/ /		/ /							
(REQUIRED FOR CHILD CARE ONLY)		/ /		/ /							
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: _____

Address: _____

Telephone: _____

Date of Physical Exam: _____

Date This Form Completed: _____

Signature _____

☐ Physician ☐ Physician's Assistant ☐ Nurse Practitioner