



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

State Form 49969 (R3 / 11-11)

**BUREAU OF CHILD CARE
DIVISION OF FAMILY RESOURCES**

Name of child (last, first)		Date of birth (month, day, year)	Date of admission (month, day, year)
Address (number and street, city, state, and ZIP code)			
Child lives with (relationship)	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 (month, day, year)	Age of child
Skin	Heart
Lymphnodes	Lungs
Eyes	Abdomen
Ears	Genitalia
Nasopharynx	Skeleton
Teeth and Mouth	Other:

Note any unusual findings:

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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:

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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

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

	1	2	3	4	5
DTaP / DT					

	1	2	3	4
Hib				

	1	2	3	4	5
IPV (Polio)					

	1	2	3	4	5
* Influenza (Flu)					

	1	2
Measles Mumps Rubella (MMR)		

	1	2	3
Rotavirus (RGE)			

	1	2	or Chicken Pox Disease	Month / year
Varicella (Varivax)				

	1	2	3	4
Pneumococcal (PCV) (Prevnar)				

	1	2
HEPA		

	1	2	3
HBV (HEP B)			

* Recommended yearly.

Name of physician / nurse practitioner completing form (please print)

Telephone number
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Signature of physician / nurse practitioner

ADDITIONAL NOTES AND INSTRUCTIONS
