

# 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/<br>DT/Td (DIPHTHERIA, TETANUS AND<br>[ACELLULAR] PERTUSSIS OR TETANUS<br>AND DIPHTHERIA ONLY) | / /                      | / / | / / | / / | / / |
| MMR (MEASLES, MUMPS, AND RUBELLA)   | / /                      | / / | / / | / / | / / |
| HIB MENINGITIS (REQUIRED FOR CHILD CARE ONLY)<br>(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