

FOR ECE STUDENTS ONLY - ONE PER CHILD

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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 <small>(DIPHTHERIA, TETANUS AND [ACELLULAR] PERTUSSIS OR TETANUS AND DIPHTHERIA ONLY)</small>	/ /	/ /	/ /	/ /	/ /
MMR <small>(MEASLES, MUMPS, AND RUBELLA)</small>	/ /	/ /	/ /	/ /	/ /
HIB MENINGITIS <small>(REQUIRED FOR CHILD CARE ONLY) (HAEMOPHILUS B)</small>	/ /	/ /	/ /	/ /	/ /
HEPATITIS B	/ /	/ /	/ /	/ /	/ /
VARICELLA <small>(CHICKENPOX)</small>	/ /	/ /	/ /	/ /	/ /

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