Medical Report of Child in Day Care

To Be Completed By Physician, Physician's Assistant or Nurse Practitioner

Name	Date of Birth	Date of Exam
	/ /	/ /

IMMUNIZATIONS

If one or more of the required medical immunizations is deemed detrimental to this child's health, attach certificate specifying which immunization(s) and complete and sign medical exemption statement on back of form.

Include All Dates

	1st	2nd	3rd	Booster	Booster
DPT	/ /	/ /	/ /	/ /	/ /
ORAL POLIO	1st / /	2nd / /	3rd / /	Booster / /	Booster / /
Hib(conjugate preferred)	1st / /	2nd / /	3rd / /	4th / /	
Hepatitis B	1st / /	2nd / /	3rd / /		
MMR	1st / /	2nd / /			

Other Immunizations

Type	Date
	/ /
Type	Date / /
Type	Date / /

TESTS

Tuberculin Test

____/____/____
Date

Pos	Neg
☐	☐

Results

Tine	Mantoux
☐	☐

Specify

If positive, attach physician's statement documenting treatment and follow-up.

Lead Screening

____/____/____
Date

Attach statement of lead screening.

HEALTH SPECIFICS		Comments:
☐ Yes ☐ No	Are there allergies? (Specify)	
☐ Yes ☐ No	Is medication regularly taken? (Specify drug and condition)	
☐ Yes ☐ No	Is a special diet required? (Specify diet and condition)	
☐ Yes ☐ No	Are there any hearing, visual or dental conditions requiring special attention?	
☐ Yes ☐ No	Are there any medical or developmental conditions requiring special attention?	

SUMMARY OF PHYSICAL EXAM (including special recommendations to Day Care Provider)

On the basis of my findings as indicated above and on my knowledge of the above named child, I find that: (s)he is free from contagious and communicable disease ☐ *Yes* ☐ *No and is able to participate in day care* ☐ *Yes* ☐ *No*

Signature of Examiner

Address

Name (please print)

City, State, Zip

Title

( ) Phone

/ / Date

Medical Exemptions

The physical condition of the above named child is such that immunization would endanger life or health.

Physician's Signature	Date
X	_____ / _____ / _____