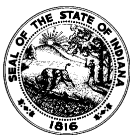

# HEALTH CARE PROGRAM FOR CHILD CARE CENTERS
# CHILD CARE CENTER HEALTH RECORD

State Form 45877 (R3 / 10-02) / BCD 0054

**CHILDCARE HEALTH SECTION**
**BUREAU OF CHILD DEVELOPMENT**
**DIVISION OF FAMILY AND CHILDREN**

| Name of child (*last, first*) | Date of birth | Admission date |
|---|---|---|
| Address (*number and street, city, state, 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 | Age of child |
| Skin | Heart |
| Lymphnodes | Lungs |
| Eyes | Abdomen |
| Ears | Genitalia |
| Nasopharynx | Skeleton |
| Teeth and Mouth | Other: |

Note any unusual findings:

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:

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

(*Over*)

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

| | 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|---|
| **DTP / DT / Td** | | | | | |

| | 1 | 2 | 3 | 4 |
|---|---|---|---|---|
| **Hib** | | | | |

| | 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|---|
| **IPV** | | | | | |

| | 1 | 2 |
|---|---|---|
| **Measles** | | |

| | 1 | 2 |
|---|---|---|
| **Mumps** | | |

| | 1 | 2 |
|---|---|---|
| **Rubella** | | |

| | 1 | 2 |
|---|---|---|
| **Varicella** | | |

| | 1 | 2 | 3 | 4 |
|---|---|---|---|---|
| **Pmeumococcal (PCV)** | | | | |

| | 1 | 2 | 3 |
|---|---|---|---|
| **HBV** | | | |

NOTE: To be considered adequately immunized, a child of age twenty-four months should have received four DTP inoculations, three polio inoculations, one inoculation against measles, mumps, and rubella, and at least 3 Hib vaccinations.

| Name of physician completing form (*please print*) | Telephone number |
|---|---|
| | |

Signature of physician

## ADDITIONAL NOTES AND INSTRUCTIONS