

CHILD DAY CARE CENTER HEALTH RECORD

Indiana State Department of Health

Child's Name _____
(last) (first)

Birth Date ____/____/____
 Admission Date ____/____/____

Street Address _____ City _____ Zip _____

Child lives with _____ Name _____ Phone _____
(relationship)

MEDICAL HISTORY

Communicable Disease	Month/Year	Condition	Explain if present
Measles	_____	Allergies: _____ Handicapping Conditions: _____ Other: _____	_____
Rubella (Ger. Measles)	_____		_____
Chickenpox	_____		_____
Mumps	_____		_____
Scarlet Fever	_____		_____
Whooping Cough	_____		_____
Other _____	_____		_____

PHYSICAL EXAMINATION

Date of Exam _____ Age of Child _____

Skin _____ Lymphnodes _____ Eyes _____ Ears _____ Nasopharynx _____ Teeth & Mouth _____	Heart _____ Lungs _____ Abdomen _____ Genitalia _____ Skeleton _____ Other _____
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Note any unusual findings: _____

Does this child have any health condition that would be hazardous either to him/herself or to other children in a group setting as a result of participation in normal activities (including sports)? No ___ Yes ___. If yes, what modification of normal activities would be necessary to protect the child and his/her classmates: _____

Have you prescribed any medications or special routines which should be included in the center's plans for this child's activities No ___ Yes ___ Explain: _____

(Over)

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

	1	2	3	4	5
DTP/DT/Td					

	1	2	3	4	5
TOPV					

	1	2
Measles		

	1	2
Mumps		

	1	2
Rubella		

	1	2	3	4
Hib				

Intradermal TB Test:	_____
	(date) (result)

NOTE: To be considered adequately immunized a child of age twenty-four months should have received four DTP inoculations, three trivalent oral polio feedings, and one inoculation against measles, mumps, and rubella and at least 3 Hib vaccinations. An intradermal tuberculin skin test must also have been performed and read.

Name of Physician Completing Form: _____ Phone Number _____
(Please Print)

Physician's Signature _____

ADDITIONAL NOTES AND INSTRUCTIONS

