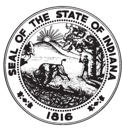

HEALTH CARE PROGRAM FOR CHILD CARE CENTERS
CHILD CARE CENTER HEALTH RECORD

State Form 49969 (R3 / 11-11)

BUREAU OF CHILD CARE
DIVISION OF FAMILY RESOURCES

Name of child (*last, first*)	Date of birth (*month, day, year*)	Date of admission (*month, day, year*)
Address (*number and street, city, state, and 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 (*month, day, year*)	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

Date Signed ___________________________

(*Over*)

Doctor Signature_________________________

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

	1	2	3	4	5
DTaP / DT					
Hib					
IPV (Polio)					
* **Influenza (Flu)**					
Measles Mumps Rubella (MMR)					
Rotavirus (RGE)					
Varicella (Varivax)					
Pneumococcal (PCV) (Prevnar)					
HEPA					
HBV (HEP B)					

or Chicken Pox Disease Month / year

* Recommended yearly.

Name of physician / nurse practitioner completing form (*please print*)

Telephone number
(   )

Signature of physician / nurse practitioner

ADDITIONAL NOTES AND INSTRUCTIONS

Date Signed ______________________________ Doctor Signature ___________________________