



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 (<i>last, first</i>)	Date of birth (<i>month, day, year</i>)	Date of admission (<i>month, day, year</i>)
Address (<i>number and street, city, state, and ZIP code</i>)		
Child lives with (<i>relationship</i>)	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 (<i>month, day, year</i>)	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

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

	1	2	3	4	5
DTaP / DT					

	1	2	3	4
Hib				

	1	2	3	4	5
IPV (Polio)					

	1	2	3	4	5
* Influenza (Flu)					

	1	2
Measles Mumps Rubella (MMR)		

	1	2	3
Rotavirus (RGE)			

	1	2	
Varicella (Varivax)			

or Chicken Pox Disease

Month / year

	1	2	3	4
Pneumococcal (PCV) (Prevnar)				

	1	2
HEPA		

	1	2	3
HBV (HEP B)			

* Recommended yearly.

Name of physician / nurse practitioner completing form <i>(please print)</i>	Telephone number ()
--	------------------------------

Signature of physician / nurse practitioner

ADDITIONAL NOTES AND INSTRUCTIONS

Trinity Child Care / Fax #:317-489-6053
