



HEALTH CARE PROGRAM FOR CHILD CARE HEALTH RECORD - CHILD

State Form 49969 (R5 / 7-19)

FAMILY AND SOCIAL SERVICES
ADMINISTRATION - MS02
402 W. Washington St., Room W362
Indianapolis, IN 46204

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
		Allergies:	
		Handicapping conditions:	
Screenings	Result / Date (<i>month, day, year</i>)		
TB Risk / Symptom		Other:	
Developmental Screen			
Lead			

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 (<i>including sports</i>)?	
☐ 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
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)			

Varicella (Varivax)	1	2	or Chicken Pox Disease	Month / year

	1	2	3	4
Pneumococcal (PCV) (Prevnar)				

	1	2
HEP A		

	1	2	3
HBV (HEP B)			

* Recommended yearly.

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

ADDITIONAL NOTES AND INSTRUCTIONS

[illegible]