

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 (month, day, year)	Date of admission (month, day, year)		
Address (number and street, city, state, and	d ZIP code)				
Child lives with (relationship)	Name		Telephone number		
Crilia lives with (relationship)	Ivanie		()		
			,		
	MEDICA	L HISTORY			
Communicable Disease	Month / Year	Condition	Explain if present		
		Allergies:			
		Handicapping conditions:			
Screenings	Result / Date (month, day, year)				
TB Risk / Symptom		Other:			
Developmental Screen					
Lead					
	PHYSICAL	EXAMINATION			
Date of exam (month, day, year)		Age of child			
01:		<u> </u>			
Skin		Heart			
Lymphnodes		Lungs			
Eyes Ears		Abdomen Genitalia			
Nasopharynx		Skeleton			
Teeth and Mouth		Other:			
Note any unusual findings:		Other.			
rtote any anacaan manige.					
			of participation in normal activities (including sports)?		
Yes No If Yes, what modificat	ion of normal activities would be necessary to	protect the child and the child's classm	ates:		
Have you prescribed any medications or sp	pecial routines which should be included in the	center's plans for this child's activities?	P Explain:		
☐ Yes ☐ No		•			

1 2 Measles Mumps Rubella (MMR) 1 2 3 Rotavirus (RGE) 1 2				пізток	Y OF IMMUNIZA	TIONS AND TE	.51 (Illulcate I
1			1	2	3	4	5
Hib		DTaP / DT					
Hib							
1 2 3 4 5 IPV (Polio) 1 2 3 4 5 Influenza (Flu) 1 2 3 Measles Mumps Rubella (MMR) 1 2 3 Rotavirus (RGE) 1 2 3 Varicella (Varivax) 1 2 3 4 Pneumococcal (PCV) (Prevnar) 1 2 3 4 Pheumococcal (PCV) (Prevnar) 1 2 3 4 Pheumococcal (PCV) (Prevnar) 1 2 3 4 Preumococcal (PCV) (Prevnar) 1 2 3 4 Preumococcal (PCV) (Prevnar)			1	2	3	4	
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IPV (Polio)							
1 2 3 4 5 Influenza (Flu) 1 2 Measles Mumps Rubella (MMR) 1 2 3 Rotavirus (RGE) 1 2 or Chicken Pox Disease Month / year (Varivax) 1 2 3 4 Pneumococcal (PCV) (Prevnar) 1 2 3 HEP A 1 2 3 HEP A 1 2 3 HEP A			1	2	3	4	5
Influenza (Flu)		IPV (Polio)					
Influenza (Flu)			4	2	2	4	-
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1			1	2	¬		
1 2 3 4 Pneumococcal (PCV) (Prevnar) 1 2 HEP A 1 2 3 HBV (HEP B) * Recommended yearly.		Varicella (Varivax)			or Chicker	n Pox Disease	Month / ye
Pneumococcal (PCV) (Prevnar) 1 2 HEP A 1 2 3 HBV (HEP B) * Recommended yearly.			<u> </u>	I			
1 2 3 HBV (HEP B) * Recommended yearly.			1	2	3	4	
1 2 HEP A 1 2 3 HBV (HEP B) * Recommended yearly.		Pneumococcal (PCV) (Prevnar)					
HEP A 1 2 3 HBV (HEP B) * Recommended yearly.							
1 2 3 HBV (HEP B) * Recommended yearly.			1	2	7		
HBV (HEP B) * Recommended yearly.		HEP A					
HBV (HEP B) * Recommended yearly.			4	•	•		
* Recommended yearly.		HBV	1	2	3		
* Recommended yearly. ame of physician / nurse practitioner / physician assistant completing form (please print)		(HEP B)					
amo or priyololari / mailoo pravataviror / priyololari aoolotarik completing 10111 (preade print)	Į2	* Recommended	yearly.	nhysician assistan	t completing form	(nlease print)	
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