



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

State Form 49969 (R4 / 2-15)

FSSA - MS02
402 WEST WASHINGTON STREET, RM W361
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 (*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)			

Varicella (Varivax)	<div style="display: flex; justify-content: space-around;"> 1 2 </div>		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 completing form (<i>please print</i>)	Telephone number ()
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Signature of physician / nurse practitioner

ADDITIONAL NOTES AND INSTRUCTIONS

[illegible]