

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

FSSA - MS02 402 WEST WASHINGTON STREET, RM W361 INDIANAPOLIS, IN 46204

State Form 49969 (R4 / 2-15)

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	ZIP code)											
Child lives with (relationship)	Name		Telephone number									
	I		,									
MEDICAL HISTORY												
Communicable Disease	Month / Year	Condition	Explain if present									
		Allergies:										
		Handicapping conditions:										
Screenings	Result / Date (month, day, year)											
TB Risk / Symptom		Other:										
Developmental Screen		4										
Lead												
	BUNGLOAL	EVANUATION										
Date of exam (month, day, year)	PHYSICAL	EXAMINATION  Age of child										
Date of exam (month, day, year)		, tgc or orma										
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 oth	ner children in a group setting as a result of	participation in normal activities (including sports)?									
Yes No If Yes, what modification	on of normal activities would be necessary to	protect the child and the child's classma	ites:									
Have you prescribed any medications or spe	ecial routines which should be included in the	center's plans for this child's activities?	Explain:									
Yes No	Saurico Willon Should De moldded III the	. 35or o piano for tillo offilia o dottvitios:	—									

Signature of physician / nurse practitioner	HISTORY OF IMMUNIZATIONS AND TEST (indicate i						
1	_		1	2	3	4	5
Hib		DTaP / DT					
Hib	L						
1	-		1	2	3	4	
IPV (Polio)		Hib					
IPV (Polio)	L						
1	-		1	2	3	4	5
* Influenza (Flu)  1 2  Measles Mumps Rubella (MMR)  1 2 3  Rotavirus (RGE)  1 2  Varicella (Varivax)  1 2 3 4  Pneumococcal (PCV) (Prevnar)  1 2 3 4  Phep A  1 2 3  HBV (HEP B)  * Recommended yearly.  Name of physician / nurse practitioner completing form (please print)  Tel ( Signature of physician / nurse practitioner		IPV (Polio)					
* Influenza (Flu)  1 2  Measles Mumps Rubella (MMR)  1 2 3  Rotavirus (RGE)  1 2  Varicella (Varivax)  1 2 3 4  Pneumococcal (PCV) (Prevnar)  1 2 3 4  Phep A  1 2 3  HBV (HEP B)  * Recommended yearly.  Name of physician / nurse practitioner completing form (please print)  Tel ( Signature of physician / nurse practitioner	L						
1   2   3	_		1	2	3	4	5
1   2   3	*	Influenza (Flu)					
Measles Mumps Rubella (MMR)  1 2 3  Rotavirus (RGE)  1 2  Varicella (Varivax)  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 (please print)  Tel ( Signature of physician / nurse practitioner	L	. ,					
The state of physician / nurse practitioner completing form (please print)  To Chicken Pox Disease  Month / year and a state of physician / nurse practitioner completing form (please print)  Tele (				2	1		
Rotavirus (RGE)  1 2 Varicella (Varivax)  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 (please print)  Tel ( Signature of physician / nurse practitioner		Measles Mumps					
Rotavirus (RGE)  1 2 Varicella (Varivax)  1 2 3 4 Pneumococcal (PCV) (Prevnar)  1 2 HEP A  1 2 3 HBV (HEP B)  * Recommended yearly.  Name of physician / nurse practitioner  Signature of physician / nurse practitioner	L	Rubella (IVIIVIR)					
Rotavirus (RGE)  1 2 Varicella (Varivax)  1 2 3 4 Pneumococcal (PCV) (Prevnar)  1 2 HEP A  1 2 3 HBV (HEP B)  * Recommended yearly.  Name of physician / nurse practitioner  Signature of physician / nurse practitioner			1	2	3		
The state of physician / nurse practitioner of the state		Rotavirus (RGE)					
Varicella (Varivax)  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 (please print)  Tel (Signature of physician / nurse practitioner	L						
Varicella (Varivax)  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 (please print)  Tel (Signature of physician / nurse practitioner			1	2			
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 (please print)  Signature of physician / nurse practitioner		Varicella	-		or Chicken	n Pox Disease	Month / y
Pneumococcal (PCV) (Prevnar)  1 2  HEP A  1 2 3  HBV (HEP B)  * Recommended yearly.  Name of physician / nurse practitioner completing form (please print)  Signature of physician / nurse practitioner	L	(Varivax)			3. 3.110.00	Ox 2100u30	
Pneumococcal (PCV) (Prevnar)  1 2  HEP A  1 2 3  HBV (HEP B)  * Recommended yearly.  Name of physician / nurse practitioner completing form (please print)  Signature of physician / nurse practitioner			1	2	3	А	
(PCV) (Prevnar)  1 2  HEP A  1 2 3  HBV (HEP B)  * Recommended yearly.  Name of physician / nurse practitioner completing form (please print)  Signature of physician / nurse practitioner	Γ	Pneumococcal				<b>"</b>	
HEP A  1 2 3  HBV (HEP B)  * Recommended yearly.  Name of physician / nurse practitioner completing form (please print)  Tel (		(PCV) (Prevnar)					
Tel (  Tel (  Signature of physician / nurse practitioner			4	2			
1 2 3  HBV (HEP B)  * Recommended yearly.  Name of physician / nurse practitioner completing form (please print)  Tel (	Γ		1	2			
* Recommended yearly.  Name of physician / nurse practitioner completing form (please print)  Teld (  Signature of physician / nurse practitioner		HEP A					
* Recommended yearly.  Name of physician / nurse practitioner completing form (please print)  Teld (  Signature of physician / nurse practitioner				_	•		
* Recommended yearly.  Name of physician / nurse practitioner completing form (please print)  Tele (  Signature of physician / nurse practitioner	Г	HRV	1	2	3		
Name of physician / nurse practitioner completing form (please print)  Signature of physician / nurse practitioner		(HEP B)					
Signature of physician / nurse practitioner							
Signature of physician / nurse practitioner  ADDITIONAL NOTES AND INSTRUCTION  ADDITIONAL NOTES AND INSTRUCT				ompleting form (ple	ase print)		Te
	Sia	nature of physician / i	nurse practitione	er			[(
ADDITIONAL NOTES AND INSTRUCTION	5		rianco praedinente	•			
					ADDITION	IAL NOTES AN	D INSTRUCTI