

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

State Form 45877 (R2 / 7-00) / BCD 0054

CHILDCARE HEALTH SECTION BUREAU OF CHILD DEVELOPMENT DIVISION OF FAMILY AND CHILDREN

Name of child (last, first)		Date of birth	Admission date
Address (number and street, city, state, ZIP cod	le)		
Child lives with (relationship)	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:							

Date of exam	PHYSICAL EXAMINATION
	Age of child
Skin	Heart
Lymphnodes	Lungs
Eyes	Abdomen
Ears	Genitalia
Nasopharynx	Skeleton
Teeth and Mouth	Other:
Note any unusual findings:	
Yes No If Yes, what modification of n	normal activities would be necessary to protect the child and the child's classmates:
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Have you prescribed any medications or special routines which sho	
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MUTHER STAN	RN 994090 (940	HISTORY	OF IMMUNIZA	TIONS AND	EST (indicate	e month / day / year)
TRANSPOLITING O	READ OF CHIL		810 Star			FAR ONLO OARE CENTER HEALTR
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DTP / DT / Td	digio rational	1		o to entit		and and it is a second
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	1	2	3	4		
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IPV						(arthur (arthur) and an arthur (arthur)
	1	2				Status - State
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Measles		1				
	1	2				
			1			
Mumps						
	1	2				
Datalla						
Rubella						
	1	2				
Varicella *			1			
Vancella						
	1	2	3			
HBV						
			<u> </u>	In the second second		
NOTE: To be con	sidered adequat	elv immunized	a child of age	twenty-four m	onths should h	ave received four DTP inoculations, three polio inoculations
			, and rubella, a	nd at least 3 H		ave received four DTP inoculations, three polio inoculations, s.
* Recommended,			and set because a	Constant of S	all free status	The state of the state sector se
ame of physician com	pleting form (pleas	e print)				Telephone number
gnature of physician						
			ADDITION	AL NOTES A	ND INSTRUC	TIONS
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