BUREAU OF CHILD CARE DIVISION OF FAMILY RESOURCES

Name of child (last, first)		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
	MED	ICAL HISTORY	
Communicable Disease	Month / Year	Condition	Explain if present
Measles		Allergies:	
Rubella (German Measles)			
Chickenpox		Handicapping conditions:	
Mumps			
Scarlet Fever		Other:	
Whooping Cough			
Other:			
	PHYSIC	AL EXAMINATION	
Date of exam (month, day, year)		Age of child	
Skin		Heart	
Lymphnodes		Lungs	
Eyes		Abdomen	
Ears		Genitalia	
Nasopharynx		Skeleton	
Teeth and Mouth		Other:	
Note any unusual findings:			
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	t would be hazardous either to the child	or to other children in a group setting as a re	sult of participation in normal activities (including
spons)? ☐ Yes ☐ No If Yes	, what modification of normal activities w	rould be necessary to protect the child and th	e child's classmates:
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Have you prescribed any medications or an			
Have you prescribed any medications or spec	cial routines which should be included in	the center's plans for this child's activities? E	ixplain:
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(Varivax)  1 2 3 4  Pneumococcal (PCV) (Prevnar)  1 2  HEPA  1 2 3  HBV (HEP B)  Recommended yearly. me of physician / nurse practitioner completing form (please print)  Tele	DTaP / DT			HISTORY	OF IMMUNIZA	TIONS AND TE	ST (indicate r
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