



MEDICAL EXAMINATION REPORT*

Completion of this information is required by the Missouri Department of Health and Senior Services Bureau of Child Care*

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| Child's Name | Date of Birth |
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Parents, please note: Children not immunized will be excluded from participating in the program during any outbreak of vaccine preventable illnesses.

- I have examined the above-named child and verify that this child's medical history and current state of health **are** **are not** satisfactory for participation in a preschool program and child care.
- This child is in the process of receiving recommended immunization vaccines. **yes** **no**
- This child requires specialized care: **yes** **no**
If yes, please explain below:

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| Comments/Recommendations: including special diets, allergies, ear infections, convulsion, diabetes, emotional problems, etc. |
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Please attach a copy of this child's current immunization records from birth through the date of this examination.

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| Signature & date of physician or RN under the supervision of a physician <div style="text-align: right;">Date:</div> | Physician or RN's name printed |
| Name of clinic, group practice, or other | If RN is supervised by a physician, indicate the physician's name |
| Address (Street, City, State, Zip Code) | Telephone number () |

*This report is kept on file at the preschool facility:
9500 Wornall Rd. Kansas City, MO 64114