MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
BUREAU OF CHILD CARE

MEDICAL EXAMINATION REPORT (INFANT/TODDLER & PRESCHOOL-AGE CHILD)

I. IDENTIFYING INFORMATION

PATIENT'S NAME	BIRTHDATE

II. CURRENT STATE OF HEALTH

I HAVE EXAMINED THE ABOVE-NAMED CHILD AND VERIFY THAT THIS CHILD'S MEDICAL HISTORY AND CURRENT STATE OF HEAL

☐ ARE ☐ ARE NOT SATISFACTORY FOR PARTICIPATION IN A CHILD CARE PROGRAM.

DOES THIS CHILD REQUIRE ANY SPECIALIZED CARE? ☐ YES ☐ NO

IF YES, EXPLAIN IN SECTION IV.

III. IMMUNIZATION HISTORY

OUR RECORDS INDICATE THAT THIS CHILD HAS THE FOLLOWING IMMUNIZATIONS:

IMMUNIZATIONS	DATES GIVEN					
	Dose No. 1	Dose No. 2	Dose No. 3	Dose No. 4	Dose No. 5	Dose No. 6
_____ DPT/DT/DTAP						
_____ Polio						
_____ Hepatitis B						
_____ Hib						
_____ MMR						
_____ Varicella						

IV. COMMENTS/RECOMMENDATIONS

(SPECIAL DIETS, ALLERGIES, EAR INFECTIONS, CONVULSIONS, DIABETES, EMOTIONAL PROBLEMS)

SIGNATURE OF PHYSICIAN OR REGISTERED NURSE UNDER THE SUPERVISION OF A PHYSICIAN ▶	DATE	PHYSICIAN'S OR NURSE'S NAME (PLEASE PRINT)
NAME OF CLINIC, GROUP PRACTICE, OTHER		IF NURSE IS SUPERVISED BY PHYSICIAN, INDICATE PHYSICIAN'S NAME
ADDRESS (STREET, CITY, STATE, ZIP CODE)		TELEPHONE NUMBER ( )