CHILD DAY CARE CENTER HEALTH RECORD

Indiana State Department of Health

Child's Name _____ (Last) _____ (First) Birth Date ____/____/____ Admission Date ____/____/____

Street Address _____ City _____ Zip _____

Child lives with _____ Name _____ Phone _____

MEDICAL HISTORY

Communicable Disease	Month/Year	Condition	Explain if present
Measles		Allergies	
Rubella (German Measles)			
Chickenpox (Varicella)		Handicapping Conditions:	
Mumps			
Scarlet Fever			
Whooping Cough		Other:	
Hepatitis B			
Other:			

PHYSICAL EXAMINATION

Date of Exam _____ Age of Child _____

Skin		Heart	
Lymph nodes		Lungs	
Eyes		Abdomen	
Ears		Genitalia	
Nasopharynx		Skeleton	
Teeth & Mouth		Other	

Note any unusual findings: _____

Does this child have any health condition that would be hazardous to him/herself or to other children in a group setting as a result of participation in normal activities (including sports)? No ____ Yes ____. If "Yes," what modification of normal activities would be necessary to protect the child and his/her classmates?: _____

Have you prescribed any medications or special routines which should be included in the center's plans for this child's activities?
No _____ Yes ____ Explain: _____

(Over)

HISTORY OF IMMUNIZATIONS (Indicate month/day/year)

	1	2	3	4	5	
DTaP/DT						

	1	2	3	4	
OPV, IPV					

	1	2	3	4	
Hib					

	1	2	3	
Hepatitis B				*#

	1	2	
Measles			*

	1	2	
Mumps			*

	1	2	
Rubella			*

	1	2	3	
Rotavirus				#

	1	2	
Varicella			*#

*Indicates vaccines to be assessed and given if necessary during early adolescence.
#Not required for daycare attendance, for statistical purposes only.

Name of Physician Completing Form: _____ Phone Number: _____
(Please Print)

Physician's Signature: _____

ADDITIONAL NOTES AND INSTRUCTIONS

_____
_____
_____
_____
_____

SDH23-034 (R/2-99)
State Form 23923