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

State Form 49969 (R4 / 2-15)

FSSA· MS02
402 WEST WASHINGTON STREET, RM W361
INDIANAPOUS, IN 46204

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 n)mber

MEDICAL HISTORY

Communicable Disease	Month/ Year	Condition	Explain if present
		Allergies:	
Screenings	Result/ Date *(month, day, year)*	Handicapping conditions:	
TB Risk i Sympto m Developmental Screen		Other:	
Lead			

PHYSICAL 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:

Does this child have any health condition that would be hazardous either to the child or to other children in a group setting as a result of participation in normal activities *(including sports)?*

0 Yes O No If Yes, what modification of normal activities would be necessary to protect the child and the child's classmates:

Have you prescribed any medications or special routines which should be included in the center's plans for lhis child's activities? Explain:

D Yes D No

(Over)

HISTORY OF IMMUNIZATIONS AND TEST (*indicate month / day / year*)

	1	2	3	4	5
DTaP / DT					

	1	2	3	4
Hib				

	1	2	3	4	5
iPV (Polio)					

	1	2	3	4	5
* Influenza (Flu)					

	1	2
Measles Mumps! Rubella (MMR)		

	1	2	3
Rotavirus (RGE)			

	1	2		
Varicella (Varivax)			or Chicken Pox Disease	Month/ year

	1	2	3	4
Pneumococcal (PCV) (Prevnar)				

	1	2
HEPA		

	1	2	3
HBV (HEP B)			

* Recommended yearly.

Name of physician / nurse practitioner completing form *(please print)*	Telephone number ( )
Signature of physician/ nurse practitioner	

ADDITIONAL NOTES AND INSTRUCTIONS