The Early Childhood Center **Date Submitted:**_____

MEDICAL REPORT

NAME OF PERSON BEING EXAMINED **DATE OF BIRTH** **DATE OF EXAMINATION**

- **The above named child was examined and found to present no hazard from contagious and communicable disease, and is in good general health.**

Immunizations

TYPE	DATES	TYPE	DATES
DPT		HIB	
OPV		HEPB	
MMR		HEPA	
Influenza		VAR	

Tuberculin Test (Type) **Results:**

_____

1. Are there allergic problems? _____**Yes** _____**No**

If Yes, specify:_____

2. Is a special diet required? _____**Yes** _____**No**

If Yes, specify:_____

___

3. Is medication regularly taken? _____Yes _____No

If Yes, specify:_____

4. Are there any conditions requiring special attention by the day care provider? _____Yes_____No

If Yes, specify:_____

5. Condition of Teeth:_____

6. Hearing Tested: Date_____ Method_____ Results_____

7. Vision Tested: Date_____ Method_____ Results_____

8. Mental growth and development _____Normal _____Abnormal

If abnormal, describe:_____

_____

9. Physical growth _____Normal _____Abnormal

If abnormal, describe:_____

_____

_____

_____

List any special recommendations about child's health (use reverse if necessary)

_____

_____

_____

_____

_____

_____

_____

NAME OF PHYSICIAN (Please Print)	SIGNATURE OF PHYSICIAN	ADDRESS