

# PHYSICIAN'S REPORT—CHILD CARE CENTERS

## (CHILD'S PRE-ADMISSION HEALTH EVALUATION)

### PART A – PARENT'S CONSENT (TO BE COMPLETED BY PARENT)

\_\_\_\_\_, born \_\_\_\_\_ is being studied for readiness to enter  
(NAME OF CHILD) (BIRTH DATE)

\_\_\_\_\_. This Child Care Center/School provides a program which extends from \_\_\_\_\_ : \_\_\_\_\_  
(NAME OF CHILD CARE CENTER/SCHOOL)

a.m./p.m. to \_\_\_\_\_ a.m./p.m. , \_\_\_\_\_ days a week.

Please provide a report on above-named child using the form below. I hereby authorize release of medical information contained in this report to the above-named Child Care Center.

\_\_\_\_\_  
(SIGNATURE OF PARENT, GUARDIAN, OR CHILD'S AUTHORIZED REPRESENTATIVE)

\_\_\_\_\_  
(TODAY'S DATE)

### PART B – PHYSICIAN'S REPORT (TO BE COMPLETED BY PHYSICIAN)

Problems of which you should be aware:

Hearing: \_\_\_\_\_ Allergies: medicine: \_\_\_\_\_

Vision: \_\_\_\_\_ Insect stings: \_\_\_\_\_

Developmental: \_\_\_\_\_ Food: \_\_\_\_\_

Language/Speech: \_\_\_\_\_ Asthma: \_\_\_\_\_

Dental: \_\_\_\_\_

Other (Include behavioral concerns): \_\_\_\_\_

Comments/Explanations: \_\_\_\_\_

MEDICATION PRESCRIBED/SPECIAL ROUTINES/RESTRICTIONS FOR THIS CHILD: \_\_\_\_\_

### IMMUNIZATION HISTORY: (Fill out or enclose California Immunization Record, PM-298.)

VACCINE	DATE EACH DOSE WAS GIVEN				
	1st	2nd	3rd	4th	5th
POLIO (OPV OR IPV)	/ /	/ /	/ /	/ /	/ /
DTP/DaP/ DT/Td (DIPHTHERIA, TETANUS AND [ACELLULAR] PERTUSSIS OR TETANUS AND DIPHTHERIA ONLY)	/ /	/ /	/ /	/ /	/ /
MMR (MEASLES, MUMPS, AND RUBELLA)	/ /	/ /	/ /	/ /	/ /
HIB MENINGITIS (REQUIRED FOR CHILD CARE ONLY) (HAEMOPHILUS B)	/ /	/ /	/ /	/ /	/ /
HEPATITIS B	/ /	/ /	/ /	/ /	/ /
VARICELLA (CHICKENPOX)	/ /	/ /	/ /	/ /	/ /

#### SCREENING OF TB RISK FACTORS (listing on reverse side)

- Risk factors not present; TB skin test not required.
- Risk factors present; Mantoux TB skin test performed (unless previous positive skin test documented).  
\_\_\_ Communicable TB disease not present.

I have  have not  reviewed the above information with the parent/guardian.

Physician: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: \_\_\_\_\_

Date of Physical Exam: \_\_\_\_\_

Date This Form Completed: \_\_\_\_\_

Signature \_\_\_\_\_

Physician  Physician's Assistant  Nurse Practitioner

---

---

**RISK FACTORS FOR TB IN CHILDREN:**

- \* Have a family member or contacts with a history of confirmed or suspected TB.
- \* Are in foreign-born families and from high-prevalence countries (Asia, Africa, Central and South America).
- \* Live in out-of-home placements.
- \* Have, or are suspected to have, HIV infection.
- \* Live with an adult with HIV seropositivity.
- \* Live with an adult who has been incarcerated in the last five years.
- \* Live among, or are frequently exposed to, individuals who are homeless, migrant farm workers, users of street drugs, or residents in nursing homes.
- \* Have abnormalities on chest X-ray suggestive of TB.
- \* Have clinical evidence of TB.

---

Consult with your local health department's TB control program on any aspects of TB prevention and treatment.