CHILD CARE/HEAD START HEALTH RECORD

Indiana State Form 23923 (R2/7-03)

Child's Name _____ Birth Date _____/_____/_____
(Last) (First) 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)	_____	Physical _____
Mumps	_____	Limitations: _____
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
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		Month/Year
Varicella (Varivax)			Or Chicken Pox Disease	

	1	2	3	4
Pneumococcal (PCV) (Prevnar)				

	1	2
HEPA		

	1	2	3
HBV (HEP B)			

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

Physician's Signature: _____

ADDITIONAL NOTES AND INSTRUCTIONS

_____
_____
_____
_____