

**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/DTaP/<br>DT/Td (DIPHTHERIA, TETANUS AND<br>[ACELLULAR] PERTUSSIS OR TETANUS<br>AND DIPHTHERIA ONLY) |  | / /                      |  | / / |  | / / |  | / / |  | / / |  |
| MMR (MEASLES, MUMPS, AND RUBELLA)   |  | / /                      |  | / / |  |     |  |     |  |     |  |
| (REQUIRED FOR CHILD CARE ONLY)  |  | / /                      |  | / / |  |     |  |     |  |     |  |
| HIB MENINGITIS (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.