PHYSICIAN'S REPORT—CHILD CARE CENTERS

(CHILD'S PRE-ADMISSION HEALTH EVALUATION)

PART A – PARENT'S CONSENT (TO BE COMPLETED BY PARENT) (NAME OF CHILD) (NAME OF CHILD CARE CENTER/SCHOOL) a.m./p-m. toa.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 report to the above-named Child Care Center. (SIGNATURE OF PARENT, GUARDIAN, OR CHILD'S AUTHORIZED REPRESENTATIVE) (TODAY) PART B – PHYSICIAN'S REPORT (TO BE COMPLETED BY PHYSICIAN) Problems of which you should be aware: Hearing: Allergies: medicine: Unsion: Insect stings: Developmental: Food: Language/Speech: Asthma: Dental: Other (Include behavioral concerne): 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 VACCINE DATE EACH DOSE WAS GIVEN VACCINE DIPPOTAPY (GENELULAR) PRETUGSIAND SITE TEXANUS AND PUBBLIA) (INCLUDE CONTROLL) (INCLUDE CONTROLL) (INCLUDE CALL ROUTINES/RESTRICTIONS FOR THIS CHILD: DATE EACH DOSE WAS GIVEN VACCINE DATE EACH DOSE WAS GIVEN VACCINE DIPPOTAPY (GENELULAR) PRETUGSIAND SITE TEXANUS AND PUBBLIA) (INCLUDE CONTROLL)	_:
. This Child Care Center/School provides a program which extends from	in this
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VACCINE DATE EACH DOSE WAS GIVEN 1st 2nd 3rd 4th 5th 2nd 2nd	
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POLIO (OPV OR IPV) / / / / / / / / / / / / / / / / / / /	
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MMR / / / / /	/
(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 \(\square\) have not \(\square\) reviewed the above information with the parent/guardian.	
Physician: Date of Physical Exam:	
Address: Date This Form Completed: Telephone: Signature	
☐ Physician ☐ Physician's Assistant ☐ Nurse F	

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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.

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