# HEALTH CARE PROGRAM FOR CHILD CARE CENTERS
# CHILD CARE CENTER HEALTH RECORD

State Form 49969 (R4 / 2-15)

**FSSA - MS02**
**402 WEST WASHINGTON STREET, RM W361**
**INDIANAPOLIS, IN 46204**

| Name of child (*last, first*) | Date of birth (*month, day, year*) | Date of admission (*month, day, year*) |
|---|---|---|
| Address (*number and street, city, state, and ZIP code*) | | |
| Child lives with (*relationship*) | Name | Telephone number ( ) |

## MEDICAL HISTORY

| Communicable Disease | Month / Year | Condition | Explain if present |
|---|---|---|---|
| | | Allergies: | |
| | | | |
| | | Handicapping conditions: | |
| **Screenings** | **Result / Date *(month, day, year)*** | | |
| TB Risk / Symptom | | Other: | |
| Developmental Screen | | | |
| Lead | | | |

## PHYSICAL EXAMINATION

| Date of exam (*month, day, year*) | Age of child |
|---|---|
| Skin | Heart |
| Lymphnodes | Lungs |
| Eyes | Abdomen |
| Ears | Genitalia |
| Nasopharynx | Skeleton |
| Teeth and Mouth | Other: |

Note any unusual findings:

Does this child have any health condition that would be hazardous either to the child or to other children in a group setting as a result of participation in normal activities (*including sports*)?

☐ Yes ☐ No If Yes, what modification of normal activities would be necessary to protect the child and the child's classmates:

Have you prescribed any medications or special routines which should be included in the center's plans for this child's activities? Explain:

☐ Yes ☐ No

(*Over*)

## HISTORY OF IMMUNIZATIONS AND TEST (*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 |
|---|---|---|
| **Varicella (Varivax)** | | |

**or Chicken Pox Disease** Month / year

| | 1 | 2 | 3 | 4 |
|---|---|---|---|---|
| **Pneumococcal (PCV) (Prevnar)** | | | | |

| | 1 | 2 |
|---|---|---|
| **HEP A** | | |

| | 1 | 2 | 3 |
|---|---|---|---|
| **HBV (HEP B)** | | | |

* Recommended yearly.

Name of physician / nurse practitioner completing form (*please print*)

Telephone number
( )

Signature of physician / nurse practitioner

## ADDITIONAL NOTES AND INSTRUCTIONS