



**HEALTH CARE PROGRAM FOR CHILD CARE
HEALTH RECORD - CHILD**

State Form 49969 (R5 / 7-19)

**FAMILY AND SOCIAL SERVICES
ADMINISTRATION - MS02**
402 W. Washington St., Room W362
Indianapolis, IN 46204

Name of child (<i>last, first</i>)		Date of birth (<i>month, day, year</i>)	Date of admission (<i>month, day, year</i>)
Address (<i>number and street, city, state, and ZIP code</i>)			
Child lives with (<i>relationship</i>)	Name		Telephone number ()

MEDICAL HISTORY

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

PHYSICAL EXAMINATION

Date of exam (<i>month, day, year</i>)	Age of child
Skin	Heart
Lymphnodes	Lungs
Eyes	Abdomen
Ears	Genitalia
Nasopharynx	Skeleton
Teeth and Mouth	Other:

Note any unusual findings:

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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:

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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

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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 / physician assistant completing form (please print)

Telephone number

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Signature of physician / nurse practitioner / physician assistant

ADDITIONAL NOTES AND INSTRUCTIONS
