

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	Date of Birth
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is being studied for readiness to enter

Name of Child Care Center/School Roseville Community Preschool
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This Child Care Center/School provides a program which extends from

Start Time (AM / PM) (Circle one)	End Time (AM / PM) (Circle one)	Number of Days per Week
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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
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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:
other:	
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)

Vaccines		Date Each Does was Given				
		1st	2nd	3rd	4th	5th
POLIO (OPV OR IPV)						
DTP/DTaP/DT/Td	(DIPHTHERIA, TETANUS AND [ACELLULAR] PERTUSSIS OR TETANUS AND DIPHTHERIA ONLY)					
MMR	(MEASLES, MUMPS, AND RUBELLA)					
HIB MENINGITIS	(REQUIRED FOR CHILD CARE ONLY) (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:	Date of Physical Exam:
Address:	Date This Form Completed:
Telephone:	Signature:
Physician (check one)	Physician's Assistant
	Nurse Practitioner