PHYSICIAN'S REPORT – CHILD CARE CENTER

CHILD'S PRE-ADMISSION HEALTH EVALUATION

PART A – PARENT'S CONSENT (TO BE COMPLETED BY PARENT)

___________________________________, born _______________________ will be enrolled in St. Teresa of Avila Child
(NAME OF CHILD) (BIRTH DATE)

Development Center. This preschool/child care center provides a program in which the above named child will attend from ____:____ 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 the release of medical information contained in this report to St. Teresa of Avila Child Development 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:

Other (Include behavioral concerns)

Comments/Explanations:

Medication Prescribed/Special Routines/Restrictions for this child:

IMMUNIZATION HISTORY:

VACCINE	DATE EACH DOSE WAS GIVEN				
	1ST	2ND	3RD	4TH	5TH
POLIO (IPV OR IPV)	/ /	/ /	/ /	/ /	/ /
DTAP	/ /	/ /	/ /	/ /	/ /
MMR	/ /	/ /	/ /	/ /	/ /
HIB	/ /	/ /	/ /	/ /	/ /
HEP A	/ /	/ /	/ /	/ /	/ /
HEP B	/ /	/ /	/ /	/ /	/ /
VARICELLA	/ /	/ /	/ /	/ /	/ /
PCV	/ /	/ /	/ /	/ /	/ /
ROTAVIRUS	/ /	/ /	/ /	/ /	/ /
	/ /	/ /	/ /	/ /	/ /
	/ /	/ /	/ /	/ /	/ /

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 ☐ Physician's Assistant ☐ Nurse Practitioner