Form 18

PHYSICIAN'S REPORT FORM—DAY CARE CENTERS

STATE OF CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY DEPARTMENT OF SOCIAL SERVICES COMMUNITY CARE LICENSING

PHYSICIAN'S REPORT—CHILD CARE CENTERS
(CHILD'S PRE-ADMISSION HEALTH EVALUATION)

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

_____, born _____ is being studied for readiness to enter
(NAME OF CHILD) (DATE OF BIRTH)

_____. The Child Care Center/School provides a program which extends from _____
(NAME OF CHILD CARE CENTER/SCHOOL)

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 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)

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 (including behavioral concerns):

Comments/Explanations

MEDICATION PRESCRIBED/SPECIAL, ROUTINES/RESTRICTIONS FOR THE CHILD: _____

IMMUNIZATION HISTORY: (Fill out or enclose California Immunization Record, PM-298.)

VACCINE		DATE EACH DOSE WAS GIVEN				
		1st	2nd	3rd	4th	5th
POLIO	(OPV OR IPV)	/ /	/ /	/ /	/ /	/ /
DTP/DTEP/ DT/DD	(DIPTHERIA, TETANUS AND [ACELLULAR] PERTUSSIS OR TETANUS AND DIPHTHERIA ONLY)	/ /	/ /	/ /	/ /	/ /
MMR	(MIEASLES, MUMPS, AND RUBELL)	/ /	/ /	/ /	/ /	/ /
HIB MENINGITIS	(REQUIRED FOR CHILD CARE ONLY) (HAEMOPHILUS B)	/ /	/ /	/ /	/ /	/ /
HEPATITIS B		/ /	/ /	/ /	/ /	/ /
VARICELLA	(NOT REQUIrED) (CHICKENPOX)	/ /	/ /	/ /	/ /	/ /

SCREENING OF TB RISK FACTORS (listing on reverse side)

❑ Risk factors not present; TB skin test not required.

❑ Risk factors present; Mentoux 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 ❑ Physician's Assistant ❑ Nurse Practitioner