

Genesis Preschool Fax # (716) 625-8192

Medical Statement of Child in Childcare

To Be Completed by Licensed Physician, Physician's Assistant or Nurse Practitioner

Name of Child	Date of Birth:	Date of Examination:
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Immunizations required for entry into day care Yes No

Medical Exemption: The physical condition of the named child is such that one or more of the immunizations would endanger life or health. Attach certification specifying the exempt immunization(s).

Diphtheria, Tetanus and Pertussis(DPT) Diphtheria and Tetanus and acellular Pertussis (DTaP)	1 st Date	2 nd Date	3 rd Date	4 th Date	5 th Date
Polio (IPV or OPV)	1 st Date	2 nd Date	3 rd Date	4 th Date	
Haemophilus influenza type B (Hib)	1 st Date	2 nd Date	3 rd Date	4 th Date or 1 st Date (if given on or after 15 month of age)	
Pneumococcal Conjugate (PCV) for those born on or after 1/1/08)	1 st Date	2 nd Date	3 rd Date	4 th Date	
Hepatitis B	1 st Date	2 nd Date	3 rd Date		
Measles, Mumps and Rubella (MMR)	1 st Date	2 nd Date			
Varicella (also known as Chicken Pox)	1 st Date	2 nd Date			

Other Immunizations may include the recommended vaccines of Rotavirus, Influenza and Hepatitis A

Type of Immunization:	Date:	Type of Immunization:	Date:
Type of Immunization:	Date:	Type of Immunization:	Date:
Type of Immunization:	Date:	Type of Immunization:	Date:

Tests

Tuberculin Test Date: _____ Mantoux Results: <input type="checkbox"/> Positive <input type="checkbox"/> Negative _____ mm <i>TB Tests are at the physician's discretion.</i> If positive, or if x-ray ordered, attach physician's statement documenting treatment and follow-up. Lead Screening Date: _____ Attach lead level statement

Health Specifics**Comments**

Are there allergies? (Specify) <input type="checkbox"/> Yes <input type="checkbox"/> No	
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Medical Statement of Child in Childcare (Cont.)

Is medication regularly taken? <input type="checkbox"/> Yes <input type="checkbox"/> No (Specify drug & condition)	
Is a special diet required? <input type="checkbox"/> Yes <input type="checkbox"/> No (Specify diet & condition)	
Are there any hearing, visual or dental <input type="checkbox"/> Yes <input type="checkbox"/> No conditions requiring special attention?	
Are there any medical or developmental <input type="checkbox"/> Yes <input type="checkbox"/> No conditions requiring special attention?	

Summary of Physical Exam (Include special recommendations to Day Care Providers)

On the basis of my findings as indicated above and on my knowledge of the named child, I find that: he/she is free from contagious and communicable disease and is able to participate in day care. Yes No

 Signature of Examiner

 Address

 Please Print Name

 City, State, Zip

 Title

 (_____) _____ Date

Phone

Date