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:

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

TB Tests are at the physician's discretion.

If positive, or if x-ray ordered, attach physician's statement documenting treatment and follow-up.

Lead Screening Date:______________________________

Attach lead level statement

Medical Statement of Child in Childcare (Cont.)

Health Specifics		**Comments**
Are there allergies? (Specify)	❑ Yes ❑ No	
Is medication regularly taken? (Specify drug & condition)	❑ Yes ❑ No	
Is a special diet required? (Specify diet & condition)	❑ Yes ❑ No	
Are there any hearing, visual or dental conditions requiring special attention?	❑ Yes ❑ No	
Are there any medical or developmental conditions requiring special attention?	❑ Yes ❑ No	

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

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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 Phone Date