

**I. IDENTIFYING INFORMATION**

PATIENT'S NAME	BIRTHDATE
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**II. CURRENT STATE OF HEALTH**

I HAVE EXAMINED THE ABOVE-NAMED CHILD AND VERIFY THAT THIS CHILD'S MEDICAL HISTORY AND CURRENT STATE OF HEALTH

ARE  ARE NOT SATISFACTORY FOR PARTICIPATION IN A CHILD CARE PROGRAM.

DOES THIS CHILD REQUIRE ANY SPECIALIZED CARE?  YES  NO

IF YES, EXPLAIN IN SECTION IV.

**III. IMMUNIZATION HISTORY**

OUR RECORDS INDICATE THAT THIS CHILD HAS THE FOLLOWING IMMUNIZATIONS:

IMMUNIZATIONS	DATES GIVEN					
	Dose No. 1	Dose No. 2	Dose No. 3	Dose No. 4	Dose No. 5	Dose No. 6
_____ DPT/DT/DTAP						
_____ Polio						
_____ Hib						
_____ MMR						
_____ Hepatitis B						

**IV. COMMENTS/RECOMMENDATIONS**

(SPECIAL DIETS, ALLERGIES, EAR INFECTIONS, CONVULSIONS, DIABETES, EMOTIONAL PROBLEMS)

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SIGNATURE OF PHYSICIAN OR REGISTERED NURSE UNDER THE SUPERVISION OF A PHYSICIAN	DATE	PHYSICIAN'S OR NURSE'S NAME (PLEASE PRINT)
NAME OF CLINIC, GROUP PRACTICE, OTHER		IF NURSE IS SUPERVISED BY PHYSICIAN, INDICATE PHYSICIAN'S NAME
ADDRESS (STREET, CITY, STATE, ZIP CODE)		TELEPHONE NUMBER (     )