

# Medical Examination Report (Infant/Toddler & Preschool-Aged Child)

## I. IDENTIFYING INFORMATION

Patient's Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_

## 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						
_____ Hepatitis B						
_____ Hib						
_____ MMR						
_____ Varicella						

## 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