HEALTH CARE PROGRAM FOR CHILD CARE CENTERS
CHILD CARE CENTER HEALTH RECORD

State Form 49969 (R4 / 2-15)

FSSA - MS02
402 WEST WASHINGTON STREET, RM W361
INDIANAPOLIS, IN 46204

Name of child (*last, first*)	Date of birth (*month, day, year*)	Date of admission (*month, day, year*)
Address (*number and street, city, state, and ZIP code*)		
Child lives with (*relationship*)	Name	Telephone number ( )

MEDICAL HISTORY

Communicable Disease	Month / Year	Condition	Explain if present
		Allergies:	
		Handicapping conditions:	
Screenings	**Result / Date *(month, day, year)***		
TB Risk / Symptom		Other:	
Developmental Screen			
Lead			

PHYSICAL EXAMINATION

Date of exam (*month, day, year*)	Age of child
Skin	Heart
Lymphnodes	Lungs
Eyes	Abdomen
Ears	Genitalia
Nasopharynx	Skeleton
Teeth and Mouth	Other:

Note any unusual findings:

Does this child have any health condition that would be hazardous either to the child or to other children in a group setting as a result of participation in normal activities (*including sports*)?

☐ Yes ☐ No If Yes, what modification of normal activities would be necessary to protect the child and the child's classmates:

Have you prescribed any medications or special routines which should be included in the center's plans for this child's activities? Explain:

☐ Yes ☐ No

(*Over*)

THIS IS A REQUIRED FORM *Day Care Provider Name* _____

Child Immunization Record

Child's Name _____ **Date of Birth** _____

Parent's Name _____ **Phone** _____

Address _____
Street Address City State Zip

Record Date of Immunization

	Birth	1 mo	2 mo	4 mo	6 mo	12-18 mo	2-3 yr	4-6 yr
Hep B								
DtaP / DTP / Td								
Hib								
MMR								
IPV								
Varicella								
PCV / Prevnar								
Hep A								

Child has documented history of Varicella Disease _____No _____Yes If yes, age _____

Please check the appropriate response.

- ❑ Child has received complete age-appropriate immunizations.
- ❑ Child is currently in the process of receiving complete age-appropriate immunizations.

ONE BOX ABOVE MUST BE CHECKED BY THE HEALTH CARE PROVIDER

Comments: ***(Please list immunizations excluded for medical reasons)*** _____

_____

_____

Parent comments: (Please indicate religious objection, if any)

_____

_____

Signature_____Date_____
(Health Care Provider's Signature and Date is **Required**.)

Printed Name and Title _____
(Printed Name and Title is **Required)**

This form must be updated annually.