



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

State Form 49969 (R2 / 11-06) / BCC 0019

BUREAU OF CHILD CARE  
DIVISION OF FAMILY RESOURCES

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

### MEDICAL HISTORY

Communicable Disease	Month / Year	Condition	Explain if present
Measles		Allergies:	-----
Rubella (German Measles)			-----
Chickenpox		Handicapping conditions:	-----
Mumps			-----
Scarlet Fever		Other:	-----
Whooping Cough			-----
Other:			-----

### PHYSICAL EXAMINATION

Date of exam ( <i>month, day, year</i> )	Age of child
Skin	Heart
Lymphnodes	Lungs
Eyes	Abdomen
Ears	Genitalia
Nasopharynx	Skeleton
Teeth and Mouth	Other:
Note any unusual findings:	
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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 ( <i>including sports</i> )? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, what modification of normal activities would be necessary to protect the child and the child's classmates:	
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Have you prescribed any medications or special routines which should be included in the center's plans for this child's activities? Explain:	
<input type="checkbox"/> Yes <input type="checkbox"/> No	
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