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**Child’s Medical Report**

Child’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Child’s Parent or Guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

In addition to a medical report or medical screening, a Certificate of Immunization (ADPH-F-IMM-50) is required for all children enrolled.

*To be completed by a Physician, Physician’s Assistant or Certified Nurse Practitioner*

|  |  |
| --- | --- |
| **Health Specifics** | **Comments** |
| Are there any allergies? ( )YES ( )NO  (specify allergy and treatment) |  |
| Is medication regularly taken? ( )YES ( )NO  (specify drug and condition) |  |
| Is a special diet required? ( )YES ( )NO  (specify diet and condition) |  |
| Are there any hearing, visual, ( )YES ( )NO  or dental conditions requiring  special attention? |  |
| Are there any medical, developmental ( )YES ( )NO  conditions requiring special attention? |  |

Summary of Physical Exam (include special recommendations to Daycare 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 daycare. ( ) YES ( ) NO

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Signature of Physician, Physician’s Assistant, Certified Nurse Practitioner Date

*For your convenience the completed form may be faxed to 251-645-2450.*