

## 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 Z | P code)                                     |   |  |  |  |  |  |
| Child lives with (relationship)                | Name  |   | Telephone number (   |  |  |  |  |
|  | I   |   | ,  |  |  |  |  |
|  | MEDICA                                      | L 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)                | THISIOALL                                   | 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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|  | of normal activities would be necessary to  |   | 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 classific | ales.  |  |  |  |  |
|  |   |   |  |  |  |  |  |
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|  |   |   |  |  |  |  |  |
| Have you prescribed any medications or speci   | al routines which should be included in the | center's plans for this child's activities? | Explain:   |  |  |  |  |
| Yes No   |   |   |  |  |  |  |  |
|  |   |   |  |  |  |  |  |
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|     |                        |                    | HISTORY             | OF IMMUNIZA | THONS AND TE  | :ST (Indicate |
|-----|------------------------|--------------------|---------------------|-------------|---------------|---------------|
|     |                        | 1                  | 2                   | 3           | 4             | 5             |
|     | DTaP / DT              |                    |                     |             |               |               |
|     |                        |                    |                     |             |               |               |
|     |                        | 1                  | 2                   | 3           | 4             |               |
|     | Hib                    |                    |                     |             |               |               |
|     |                        |                    |                     |             |               |               |
|     |                        | 1                  | 2                   | 3           | 4             | 5             |
|     | IPV (Polio)            |                    |                     |             |               |               |
| ,   |                        |                    |                     |             |               |               |
|     |                        | 1                  | 2                   | 3           | 4             | 5             |
| k   | Influenza (Flu)        |                    |                     |             |               |               |
|     |                        | _                  | _                   |             |               |               |
|     | Measles Mumps          | 1                  | 2                   | ]           |               |               |
|     | Rubella (MMR)          |                    |                     |             |               |               |
|     |                        | 1                  | 2                   | 3           |               |               |
|     | Rotavirus (RGE)        | -                  |                     | <u> </u>    |               |               |
|     | notavirus (NGE)        |                    |                     |             |               |               |
|     |                        | 1                  | 2                   |             |               |               |
|     | Varicella              |                    |                     | or Chicker  | n Pox Disease | Month / y     |
|     | (Varivax)              |                    |                     |             | 2.30400       |               |
|     |                        | 1                  | 2                   | 3           | 4             |               |
|     | Pneumococcal           |                    |                     |             |               |               |
|     | (PCV) (Prevnar)        |                    |                     |             |               |               |
|     |                        | 1                  | 2                   | 7           |               |               |
|     | HEP A                  |                    |                     |             |               |               |
|     |                        |                    |                     | Ţ           |               |               |
|     |                        | 1                  | 2                   | 3           | 1             |               |
|     | HBV<br>(HEP B)         |                    |                     |             |               |               |
|     | * Recommended          | vearly.            | 1                   |             | I             |               |
| la  | me of physician / nurs | se practitioner co | ompleting form (ple | ease print) |               | Te            |
|     |                        |                    |                     |             |               | (             |
| Sig | nature of physician /  | nurse practition   | er                  |             |               |               |
|     |                        |                    |                     | ADDITION    | IAL NOTES AN  | D INSTRUCTI   |
|     |                        |                    |                     |             |               |               |
|     |                        |                    |                     |             |               |               |
|     |                        |                    |                     |             |               |               |
|     |                        |                    |                     |             |               |               |
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| -   |                        |                    |                     |             |               |               |