# CHILD'S MEDICAL RECORD

Child Care Facility: _____ Date of Examination: _____

Child's Name: _____ Sex: _____ Address: _____

Birth Term: _____ Date of Birth: _____ Birth Height:_____ Birth Weight:_____ Temp: _____

Resp.: _____ Pulse: _____ Blood Pressure: _____ Current Height:_____ Current Weight: _____

General Appearance: _____ Abnormalities: _____ Skin: _____

Heart: _____ Lungs: _____ Eyes: _____ Ears: _____ Glands: _____Abdomen:_____

Sight: _____ Hearing: _____ Allergies: _____ Spinal Check: _____

Feet: _____ Genitalia: _____ Rectum: _____ Other: _____

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## IMMUNIZATIONS

Other Immunizations:

| Type Vaccine | Date | Date | Date | Date |
|---|---|---|---|---|
| DTAP or DT | | | | |
| Poliomyelitis | | | | |
| MMR (2 doses) | | | | |
| Hib (4 doses) | | | | |
| Hepatitis B (3 doses) | | | | |
| Chicken Pox (1 dose<13; 2 doses 13 or over) | | | | |

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## TESTS

Neurological Exam (if indicated) _____ Stool Exam (if indicated) _____ Other Tests:

| Tests | Date | Results | |
|---|---|---|---|
| Urinalysis | | | |
| Hemoglobin | | | |
| TB Skin Test | | | |

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## PREVIOUS ILLNESS (with age):

Measles: _____ Tonsillitis: _____ Diphtheria: _____

Mumps:_____ Tendency to Colds: _____ Pneumonia: _____

Whooping Cough: _____ Poliomyelitis: _____ Other: _____

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## CHECK ONE AND SIGN

☐ I examined this child on the above date and found the child to be free of contagious and infectious disease.

☐ I examined this child on the above date and found the child was **NOT** free of contagious or infectious disease.
*(See reverse side for explanation)*

Date: _____ Physician's Signature: _____