



# 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 (*including sports*)?     Yes     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:

Yes     No

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