Medical Report

Child's Name: _____ **Birth Date:** _____
Sex: F M
HEALTH EXAMINATION- Check correct option below and complete information that follows.
1) ____ A complete physical examination was given on (please enter date) _____
2) ____ A current physical examination was waived due to _____

Tests	**Date**	**Results**
Tuberculin Skin or Chest X-Ray	_____	_____
Other (specify)	_____	_____

Type of vaccination	1 MM/DD/YY	2 MM/DD/YY	3 MM/DD/YY	4 MM/DD/YY	5 MM/DD/YY
Diptheria,Tetanus, Petussis					
HIB					
Poliomyelitis					
Measles					
Rubella					
Mumps					
MMR					
Hep					
Varicella					

Medical History
Chicken Pox (year):_____ Scarlet Fever (year): _____
T.B./T.B. Contact (year): _____ Frequent Ear Infections:_____
Child's Current Physical Limitations, Special Needs or Disabilities (For example: allergy, diabetes, heart disease, HIV, hepatitis, epilepsy or hospitalization in the past 12 months, and any medications prescribed for long-term, continuous use.)
Allergies (list): _____

Routine Medications: _____

Dietary Restrictions: _____

Disabilities (please be specific):_____

Other:_____

Physician's Recommendation: This child may be admitted to a group child care facility. Yes No

Comments: _____

Physician's Name: _____

Physician's Signature: _____Date: _____

Address: _____ Phone #: _____

Parent/Guardian Signature: _____Date: _____

Koala-T Care Learning Center would appreciate the return of this completed form to the center director prior to child's attendance and updated annually.