PEACE LUTHERAN EARLY CHILDHOOD PROGRAMS _____ **School Year**

MISSOURI DEPARTMENT OF HEALTH BUREAU OF CHILD CARE SAFETY & LICENSURE
MEDICAL EXAMINATION REPORT (INFANT/TODDLER & PRESCHOOL-AGE CHILD)

I. IDENTIFYING INFORMATION

PATIENT'S NAME	BIRTHDATE

II. CURRENT STATE OF HEALTH

I HAVE EXAMINED THE ABOVE-NAMED CHILD AND VERIFY THAT THIS CHILD'S MEDICAL HISTORY AND CURRENT STATE OF HEALTH
❑ ARE ❑ ARE NOT SATISFACTORY FOR PARTICIPATION IN A DAYCARE PROGRAM

DOES THIS CHILD REQUIRE ANY SPECIALIZED CARE? ❑ YES ❑ NO
IF YES, EXPLAIN IN SECTION IV

III. IMMUNIZATION HISTORY

OUR RECORDS INDICATE THAT THIS CHILD HAS HAD THE FOLLOWING IMMUNIZATIONS:

IMMUNIZATIONS	DATES GIVEN					
	Dose No. 1	Dose No. 2	Dose No. 3	Dose No. 4	Dose No. 5	Dose No. 6
_____ **DPT/DT**						
_____ **Polio**						
_____ **Hib**						
_____ **MMR**						
_____ **Hepatitis B**						
_____ **Other (Name)**						

IV. COMMENT/RECOMMENDATIONS

(SPECIAL DIETS, ALLERGIES, EAR INFECTIONS, CONVULSIONS, DIABETES, EMOTIONAL PROBLEMS)

SIGNATURE OF PHYSICIAN OR REGISTERED NURSE UNDER THE SUPERVISION OF A PHYSICIAN ►	DATE	PHYSICIAN OR NURSE'S NAME (PLEASE PRINT)
NAME OF CLINIC, GROUP PRACTICE, OTHER		IF NURSE IS SUPERVISED BY PHYSICIAN, INDICATE PHYSICIAN'S NAME
ADDRESS (STREET, CITY, STATE, ZIP CODE)		TELEPHONE NUMBER ( )

THIS REPORT IS TO BE KEPT ON FILE AT THE DAYCARE FACILITY