HEALTH CARE PROGRAM FOR CHILD CARE
HEALTH RECORD - CHILD

State Form 49969 (R5 / 7-19)

FAMILY AND SOCIAL SERVICES ADMINISTRATION - MS02
402 W. Washington St., Room W362
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 ZIP code*)		
Child lives with (*relationship*)	Name	Telephone number ( )

MEDICAL 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*)	Age of child
Skin	Heart
Lymphnodes	Lungs
Eyes	Abdomen
Ears	Genitalia
Nasopharynx	Skeleton
Teeth and Mouth	Other:

Note any unusual findings:

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:

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

Name of physician / nurse practitioner / physician assistant completing form (*please print*)	Telephone number ( )
Signature of physician / nurse practitioner / physician assistant	

ADDITIONAL NOTES AND INSTRUCTIONS