Medical Report of Child in Pearce 4 Kids

To be completed by Physician, Physician's Assistant or Nurse Practioner
Fax number 594-0223

Name	Date of Birth	Date of Exam
	/ /	/ /

IMMUNIZATIONS

If one or more of the required medical immunizations is deemed detrimental to this child's health, attach certificate specifying which immunizations and complete and sign the medical exemption statement at bottom of form.

Include all dates

DPT	1st / /	2nd / /	3rd / /	Booster / /	Booster / /
Oral Polio	1st / /	2nd / /	3rd / /	Booster / /	Booster / /
Hib (conjugate preferred)	1st / /	2nd / /	3rd / /	4th / /	
Hepatitis B	1st / /	2nd / /	3rd / /		
MMR	1st / /	2nd / /			

Other Immunizations

Type	Date
	/ /
	/ /
	/ /

TESTS

Tuberculin Test

____/____/____ Date

Pos ☐ Neg ☐ Results

Tine ☐ Mantoux ☐ Specify

If positive, attach physician's statement documenting treatment and follow-up.

Lead Screening

____/____/____ Date

Attach statement of lead screening

HEALTH SPECIFICS			COMMENTS
☐ Yes	☐ No	Are there allergies? (Specify)	
☐ Yes	☐ No	Is medication regularly taken? (Specify drug and condition)	
☐ Yes	☐ No	Is a special diet required? (Specify diet and condition)	
☐ Yes	☐ No	Are there any hearing, visual or dental conditions requiring special attention?	
☐ Yes	☐ No	Are there any medical or developmental conditions requiring special attention?	

SUMMARY OF PHYSICAL EXAM (including special recommendations to Day Care Provider)

On the basis of my findings as indicated above and on my knowledge of the above named child, I find that (s)he is free from contagious and communicable disease ___ Yes ___ No and is able to participate in day care ___ Yes ___ No

Signature of Examiner

Address

Name (please print)

City, State, Zip

Title

(_____)_____ Phone

_____/_____/_____ Date

Medical Exemptions

The physical condition of the above named child is such that immunization would endanger life or health

X _____ Physician's Signature

_____/____/_____ Date