

CHESTERFIELD ACADEMY



To be completed by parent—Medical Examination (Infant/Toddler, Preschool Child)

IDENTIFYING INFORMATION						
Patient's Name					Birthdate	
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 child care program.						
IMMUNIZATION HISTORY						
Our records indicate that this child has the following immunizations.						
Dates Given						
IMMUNIZATIONS	Dose 1	Dose 2	Dose 3	Dose 4	Dose 5	Dose 6
DPT/DT						
Polio						
Hib						
MMR						
Hepatitis B						
Varicella						
Comments/Recommendations						
Are there any restrictions on normal physical activity? (Please circle) Yes No				If yes, please specify.		
Does the child have any chronic medical condition requiring special diet or medication? (Please circle) Yes No				If yes, please specify.		
Does the child have any allergies? (Please circle) Yes No				If yes, please specify.		

To be completed by physician

The above named child is now free of any infectious or contagious disease and has my permission to attend child care. This child is medically up-to-date with immunizations.	
Physician's Signature or Registered Nurse	Physician's or Nurses' Name (Please print)
Date	
Address (Street, City, State, Zip Code)	If nurse if supervised by a physician, indicate physician's name.