



**DAYCARE/HEAD START  
HEALTH RECORD**

State Form 23923 (R2/7-03)

Child's Name \_\_\_\_\_ (Last) \_\_\_\_\_ (First) Birth Date \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Admission Date \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Street Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

Child lives with \_\_\_\_\_ Name \_\_\_\_\_ Phone \_\_\_\_\_

**MEDICAL HISTORY**

Communicable Disease	Month/Year	Condition	Explain if present
Measles	_____	Allergies	_____
Rubella (German Measles)	_____	Physical	_____
Chickenpox (Varicella)	_____	Limitations:	_____
Mumps	_____	Other: _____	_____
Scarlet Fever	_____	_____	_____
Whooping Cough	_____	_____	_____
Hepatitis B	_____	_____	_____
Other: _____	_____	_____	_____

**PHYSICAL EXAMINATION**

Date of Exam \_\_\_\_\_ Age of Child \_\_\_\_\_

Skin _____	Heart _____
Lymph nodes _____	Lungs _____
Eyes _____	Abdomen _____
Ears _____	Genitalia _____
Nasopharynx _____	Skeleton _____
Teeth & Mouth _____	Other _____

Note any unusual findings: \_\_\_\_\_  
\_\_\_\_\_

Does this child have any health condition that would be hazardous to him/herself or to other children in a group setting as a result of participation in normal activities (including sports)? No \_\_\_\_\_ Yes \_\_\_\_\_. If "Yes", what modification of normal activities would be necessary to protect the child and his/her classmates?  
\_\_\_\_\_  
\_\_\_\_\_

Have you prescribed any medications or special routines which should be included in the center's plans for this child's activities?  
No \_\_\_\_\_ Yes \_\_\_\_\_ Explain: \_\_\_\_\_  
\_\_\_\_\_

(Over)

HISTORY OF IMMUNIZATIONS (Indicate month/day/year)

	1	2	3	4	5
DTaP/DT/Td/Td					

	1	2	3	4
OPV, IPV				

	1	2	3	4
Hib				

	1	2	3
Hepatitis B			

	1	2
Measles		

	1	2
Mumps		

	1	2
Rubella		

	1	2
Varicella		

	1	2	3	4
PCV7				

Name of Physician Completing Form: \_\_\_\_\_ Phone Number: \_\_\_\_\_  
(Please Print)

Physician's Signature: \_\_\_\_\_

ADDITIONAL NOTES AND INSTRUCTIONS

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