## PHYSICIAN'S REPORT—CHILD CARE CENTERS

(NAME OF CHILD) (NAME OF CHILD) (BIRTH DATE)  This Child Care Center/School provides a program which extends from : :		<u> – PARENT'S</u>	CONSENT (	TO BE COMP	LETED B	Y PAREN	T)		
ALMINON PRESCRIBED/SPECIAL ROUTINES/RESTRICTIONS FOR THIS CHILD:    NAME   Control   C	(NAME OF CHILD)	, born	(E	BIRTH DATE)		_ is being	g studied t	for readines	ss to ente
Ann/p.m. toa.m./p.m. , days a week.  Please provide a report on above-named child using the form below. I hereby authorize release of medical information contained in this report to the above-named Child Care Center.    GIGNATURE OF PARENT, GUARDIAN, OR CHILD'S AUTHORIZED REPRESENTATIVE)	WANTE OF OUR DICARD OF DEPTH (OUR OUT)	This	s Child Care Cer	nter/School pi	ovides a p	orogram w	hich exter	nds from	:
Please provide a report on above-named child using the form below. I hereby authorize release of medical information contained in this eport to the above-named Child Care Center.    (SIGNATURE OF PARENT, GUARDIAN, OR CHILD'S AUTHORIZED REPRESENTATIVE)	·								
PART B - PHYSICIAN'S REPORT (TO BE COMPLETED BY PHYSICIAN)  Problems of which you should be aware:		-	orm bolow I bor	aby authorize	roloaco	of medica	Linformati	on contains	ad in this
Problems of which you should be aware: Hearing: Allergies:medicine: Vision: Insect stings: Developmental: Food: Language/Speech: Asthma: Dental:  Other (Include behavioral concerns):  Comments/Explanations:  MEDICATION PRESCRIBED/SPECIAL ROUTINES/RESTRICTIONS FOR THIS CHILD:  IMMUNIZATION HISTORY: (Fill out or enclose California Immunization Record, PM-298.)  VACCINE DATE EACH DOSE WAS GIVEN  VACCINE 1st 2nd 3rd 4th 5th  POLIO (OPV OR IPV) / / / / / / / / / / /  INTERCALLULARI PERTUSISS OR TETANUS AND (INCELLULARI PERTUSISS OR TETANUS AND DIPLICATION AND DIPLICATION AND DIPLICATION OF CHILD STORY AND DIPLICATION			om below. Thei	eby authorize	release	oi illedica	i iiiioiiiiati	on containe	eu iii tiiis
Problems of which you should be aware: Hearing: Allergies:medicine: Vision: Insect stings: Developmental: Food: Language/Speech: Asthma: Dental:  Other (Include behavioral concerns):  Comments/Explanations:  MEDICATION PRESCRIBED/SPECIAL ROUTINES/RESTRICTIONS FOR THIS CHILD:  IMMUNIZATION HISTORY: (Fill out or enclose California Immunization Record, PM-298.)  VACCINE DATE EACH DOSE WAS GIVEN  VACCINE 1st 2nd 3rd 4th 5th  POLIO (OPV OR IPV) / / / / / / / / / / /  INTERCALLULARI PERTUSISS OR TETANUS AND (INCELLULARI PERTUSISS OR TETANUS AND DIPLICATION AND DIPLICATION AND DIPLICATION OF CHILD STORY AND DIPLICATION									
Problems of which you should be aware: Hearing: Allergies: medicine: Vision: Insect stings:  Developmental: Food: Language/Speech: Asthma:  Dental:  Other (Include behavioral concerns):  Comments/Explanations:  MEDICATION PRESCRIBED/SPECIAL ROUTINES/RESTRICTIONS FOR THIS CHILD:  IMMUNIZATION HISTORY: (Fill out or enclose California Immunization Record, PM-298.)  VACCINE  DATE EACH DOSE WAS GIVEN  VACCINE  1st 2nd 3rd 4th 5th  POLIO (OPV OR IPV)  // / / / / / / / / / /  DIPPIPIDAP/ [ACELLULAR] PERTUSSIS OR TETANUS AND DIPPIPI ACELLULAR] PERTUSSIS OR TETANUS AND DIPPIPIPI ACELLULARD PERTUSSIS OR TETANUS AND DIPPIPIPI ACELLULARD PERTUSSIS OR TETANUS AND DIPPIPIPIPI ACELLULARD PERTUSSIS OR TETANUS AND DIPPIPIPI ACELLULARD PERTUSSIS OR TETANUS AND DIPPI		(SIGNATURE OF	PARENT, GUARDIAN, C	OR CHILD'S AUTHO	RIZED REPRE	ESENTATIVE)		(TODA	Y'S DATE)
Problems of which you should be aware:  Hearing:  Allergies: medicine:  Vision:  Insect stings:  Developmental:  Language/Speech:  Asthma:  Dental:  Cither (Include behavioral concerns):  Comments/Explanations:  MEDICATION PRESCRIBED/SPECIAL ROUTINES/RESTRICTIONS FOR THIS CHILD:  IMMUNIZATION HISTORY: (Fill out or enclose California Immunization Record, PM-298.)  VACCINE  DATE EACH DOSE WAS GIVEN  VACCINE  1st 2nd 3rd 4th 5th  POLIO (OPV OR IPV)  OTPI/DTaP/ (ACELILULAR) PERTUSSIS OR TETANUS AND (ACELILULAR) PERTUSSIS OR	PART B -	PHYSICIAN'S	S REPORT (T	O BE COMP	LETED B	Y PHYSIC	IAN)		
Hearing: Allergies: medicine:  Vision: Insect stings:  Developmental: Food:  Language/Speech: Asthma:  Dental:  Other (Include behavioral concerns):  Comments/Explanations:  MEDICATION PRESCRIBED/SPECIAL ROUTINES/RESTRICTIONS FOR THIS CHILD:  IMMUNIZATION HISTORY: (Fill out or enclose California Immunization Record, PM-298.)  VACCINE DATE EACH DOSE WAS GIVEN  1st 2nd 3rd 4th 5th  POLIO (OPV OR IPV) / / / / / / / / / / / /  OTP/DTap/ (ACELULIAR) PERTUSSIS OR TETANUS AND OTP/TIAL AND INFINITE AND							,		
Vision:  Developmental:  Enguage/Speech:  Asthma:  Dental:  Other (Include behavioral concerns):  Comments/Explanations:  MEDICATION PRESCRIBED/SPECIAL ROUTINES/RESTRICTIONS FOR THIS CHILD:  IMMUNIZATION HISTORY: (Fill out or enclose California Immunization Record, PM-298.)  VACCINE  DATE EACH DOSE WAS GIVEN  1st 2nd 3rd 4th 5th  POLIO (OPV OR IPV)  / / / / / / / / / / /  DTP/DTaP/ (ACELULAR) PERTUSSIOS OR TETANUS AND DIPHTHERIA, TETANUS AND DIPHTHERIA ONLY)  MMR (MEASLES, MUMPS, AND RUBELLA)  (REQUIRED FOR CHILD CARE ONLY)  (REASILES, MUMPS, AND RUBELLA)  (MEASLES, MUMPS, AND RUBELLA)	Problems of which you should be aware:								
Developmental: Food:  Language/Speech: Asthma:  Dental:  Other (Include behavioral concerns):  Comments/Explanations:  MEDICATION PRESCRIBED/SPECIAL ROUTINES/RESTRICTIONS FOR THIS CHILD:  IMMUNIZATION HISTORY: (Fill out or enclose California Immunization Record, PM-298.)  VACCINE  DATE EACH DOSE WAS GIVEN  1st 2nd 3rd 4th 5th  POLIO (OPV OR IPV) / / / / / / / / / / /  OTP/DTaP/ [OIPHTHERIA, TETANUS AND DIPLETIANUS AND CONTROL (REQUIRED FOR CHILD CARE ONLY)  HIB MENINGITIS (HAEMOPHILUS B) / / / / / / / / / / / / / / / / / /	Hearing:			Allergies: medic	ine:				
Language/Speech:  Dental:  Other (Include behavioral concerns):  Comments/Explanations:  MEDICATION PRESCRIBED/SPECIAL ROUTINES/RESTRICTIONS FOR THIS CHILD:  IMMUNIZATION HISTORY: (Fill out or enclose California Immunization Record, PM-298.)  VACCINE  DATE EACH DOSE WAS GIVEN  1st 2nd 3rd 4th 5th  POLIO (OPV OR IPV) / / / / / / / / / / / /  DTP/DTaP/ (ACELLULAR) PERTUSSIS OR TETANUS AND INDEX AND INDEX AND INDEX AND INDEX AND INDEX AND RUBELLA) / / / / / / / / / / / / / / / / / / /	Vision:			Insect stings:					
Dental:  Other (Include behavioral concerns):  Comments/Explanations:  MEDICATION PRESCRIBED/SPECIAL ROUTINES/RESTRICTIONS FOR THIS CHILD:  IMMUNIZATION HISTORY: (Fill out or enclose California Immunization Record, PM-298.)  VACCINE  DATE EACH DOSE WAS GIVEN  1st 2nd 3rd 4th 5th  POLIO (OPV OR IPV) / / / / / / / / /  DDTP/DTaP/ (IOPHTHERIA, TETANUS AND IOPHTHERIA, TETANUS AND IOPHTHERIA, ONLY) / / / / / / / / / / /  MMR (MEASLES, MUMPS, AND RUBELLA) / / / / / / / / / / / / / / / / / / /	Developmental:			Food:					
Other (Include behavioral concerns):  Comments/Explanations:  MEDICATION PRESCRIBED/SPECIAL ROUTINES/RESTRICTIONS FOR THIS CHILD:  IMMUNIZATION HISTORY: (Fill out or enclose California Immunization Record, PM-298.)  VACCINE  DATE EACH DOSE WAS GIVEN  1st 2nd 3rd 4th 5th  POLIO (OPV OR IPV) / / / / / / / /  DITP/DTaP/ (DIPHTHERIA, TETANUS AND DITTITAL AND EIGHTHERIA ONLY) / / / / / / / /  MMR (MEASLES, MUMPS, AND RUBELLA) / / / / / / / / / / / / / / / / / / /	Language/Speech:			Asthma:					
MEDICATION PRESCRIBED/SPECIAL ROUTINES/RESTRICTIONS FOR THIS CHILD:    IMMUNIZATION HISTORY: (Fill out or enclose California Immunization Record, PM-298.)    Vaccine   Date Each Dose Was Given	Dental:								
MEDICATION PRESCRIBED/SPECIAL ROUTINES/RESTRICTIONS FOR THIS CHILD:    IMMUNIZATION HISTORY: (Fill out or enclose California Immunization Record, PM-298.)    VACCINE   DATE EACH DOSE WAS GIVEN	Other (Include behavioral concerns):								
TABLE TO THE POLIO (OPV OR IPV)  WACCINE  Total Control of Control on Control	Comments/Explanations:								
VACCINE   TSt   2nd   3rd   4th   5th									
VACCINE   TSt   2nd   3rd   4th   5th	MEDICATION PRESCRIBED/SPECIAL ROUTINES	S/RESTRICTIONS FO	OR THIS CHILD:						
1st   2nd   3rd   4th   5th				lmmunizati	on Reco	ord. PM	-298.)		
POLIO (OPV OR IPV)			e California I				,		
DTP/DTap/ (DIPHTHERIA, TETANUS AND [ACELLULAR] PERTUSSIS OR TETANUS	IMMUNIZATION HISTORY: (Fill	out or enclos	e California I	ATE EACH [	OSE WA	S GIVEN	, 		
MMR (MEASLES, MUMPS, AND RUBELLA)	IMMUNIZATION HISTORY: (Fill	out or enclos	e California I	ATE EACH [	OSE WA	S GIVEN	, 	5	th
(REQUIRED FOR CHILD CARE ONLY) HIB MENINGITIS (HAEMOPHILUS B)  / / / / / /  HEPATITIS B  / / / / /	VACCINE  POLIO (OPV OR IPV)  OTP/DTap/ (DIPHTHERIA, TETANUS AND [ACELLULAR] PERTUSSIS OR TETANUS	out or enclos	e California I	ATE EACH [	OSE WA	S GIVEN	, 	5 /	th /
HEPATITIS B / / / / /	VACCINE  POLIO (OPV OR IPV)  DTP/DTaP/ DT/Td AND DIPHTHERIA, TETANUS AND EACHLULAR) PERTUSSIS OR TETANUS AND DIPHTHERIA ONLY)  (MEASI ES, MIIMPS, AND RUBELLA)	out or enclos	e California I	ATE EACH [	OSE WA	S GIVEN	, 	5 /	th /
	VACCINE  POLIO (OPV OR IPV)  DTP/DTaP/ [ACELLULAR] PERTUSSIS OR TETANUS AND DIPHTHERIA ONLY)  MMR (MEASLES, MUMPS, AND RUBELLA)  (REQUIRED FOR CHILD CARE ONLY)	out or enclos	e California I	ATE EACH [	OSE WA	S GIVEN	, 	5 / /	th /
VARICELLA (CHICKENPOX) / / /	VACCINE  POLIO (OPV OR IPV)  DTP/DTaP/ (DIPHTHERIA, TETANUS AND [ACELLULAR] PERTUSSIS OR TETANUS AND DIPHTHERIA ONLY)  MMR (MEASLES, MUMPS, AND RUBELLA)  (REQUIRED FOR CHILD CARE ONLY)  HIB MENINGITIS (HAEMOPHILUS B)	out or enclos	e California I	ATE EACH [	OSE WA	S GIVEN	, 	5 /	th /
	VACCINE  POLIO (OPV OR IPV)  DTP/DTaP/ (DIPHTHERIA, TETANUS AND [ACELLULAR] PERTUSSIS OR TETANUS AND DIPHTHERIA ONLY)  MMR (MEASLES, MUMPS, AND RUBELLA)  (REQUIRED FOR CHILD CARE ONLY)  HIB MENINGITIS (HAEMOPHILUS B)	out or enclos	e California I	ATE EACH [	OSE WA	S GIVEN	, 	5 /	th /
	VACCINE  POLIO (OPV OR IPV)  DTP/DTaP/ (DIPHTHERIA, TETANUS AND [ACELLULAR] PERTUSSIS OR TETANUS AND DIPHTHERIA ONLY)  MMR (MEASLES, MUMPS, AND RUBELLA)  (REQUIRED FOR CHILD CARE ONLY)  HIB MENINGITIS (HAEMOPHILUS B)  HEPATITIS B  VARICELLA (CHICKENPOX)	1st / / / / / / / / / / / / / / / / / / /	e California I  2nd / / / / / / / / / /	ATE EACH [	OSE WA	S GIVEN	, 	5 /	th /
TB Skin Test is required by	VACCINE  POLIO (OPV OR IPV)  DTP/DTaP/ (DIPHTHERIA, TETANUS AND [ACELLULAR] PERTUSSIS OR TETANUS AND DIPHTHERIA ONLY)  MMR (MEASLES, MUMPS, AND RUBELLA)  (REQUIRED FOR CHILD CARE ONLY)  HIB MENINGITIS (HAEMOPHILUS B)  HEPATITIS B  VARICELLA (CHICKENPOX)	1st / / / / / / / / / / / / / / / / / / /	e California I  2nd / / / / / / / / / /	ATE EACH [	OSE WA	S GIVEN	, 	5 /	th /
	VACCINE  POLIO (OPV OR IPV)  DTP/DTaP/ [ACELLULAR] PERTUSSIS OR TETANUS AND DIPHTHERIA ONLY)  MMR (MEASLES, MUMPS, AND RUBELLA)  (REQUIRED FOR CHILD CARE ONLY)  HIB MENINGITIS (HAEMOPHILUS B)  HEPATITIS B  VARICELLA (CHICKENPOX)	out or enclos  1st / / / / / / / / / / required	e California I  2nd / / / / / / / / / /	ATE EACH [	OSE WA	S GIVEN	, 	5 /	th /
TB Skin Test is required by United Christian Education Center	VACCINE  POLIO (OPV OR IPV)  DTP/DTaP/ [ACELLULAR] PERTUSSIS OR TETANUS AND DIPHTHERIA, TETANUS AND DIPHTHERIA ONLY)  MMR (MEASLES, MUMPS, AND RUBELLA)  (REQUIRED FOR CHILD CARE ONLY)  HIB MENINGITIS (HAEMOPHILUS B)  HEPATITIS B  VARICELLA (CHICKENPOX)  TB Skin Test is	out or enclos  1st / / / / / / / / / / required	e California I  2nd / / / / / / / / / /	ATE EACH [	OSE WA	S GIVEN	, 	5 /	th /
United Christian Education Center	VACCINE  POLIO (OPV OR IPV)  DTP/DTap/ (ACELLULAR) PERTUSSIS OR TETANUS AND IACELLULAR) PERTUSSIS OR TETANUS AND DIPHTHERIA ONLY)  MMR (MEASLES, MUMPS, AND RUBELLA)  (REQUIRED FOR CHILD CARE ONLY)  HIB MENINGITIS (HAEMOPHILUS B)  HEPATITIS B  VARICELLA (CHICKENPOX)  TB Skin Test is  United Christian E	1st / / / / / / / / / / required ducation	e California I  2nd / / / / / / / / / / / / / / Center	31   /     /       /	POSE WA	AS GIVEN	, 	5 /	th /
United Christian Education Center  I have  have not  reviewed the above information with the parent/guardian.	VACCINE  POLIO (OPV OR IPV)  DTP/DTap/ (ACELLULARI) PERTUSSIS OR TETANUS AND DIPHTHERIA ONLY)  MMR (MEASLES, MUMPS, AND RUBELLA)  (REQUIRED FOR CHILD CARE ONLY) HIB MENINGITIS (HAEMOPHILUS B)  HEPATITIS B  VARICELLA (CHICKENPOX)  TB Skin Test is  United Christian E	out or enclos  1st / / / / / / / / / / / required ducation	e California I  2nd / / / / / / / / / / / /  by  Center	ATE EACH E	POSE WA	4 / /	th / / /	/	/
United Christian Education Center	VACCINE  POLIO (OPV OR IPV)  DTP/DTaP/ (ACELLULARI PERTUSSIS OR TETANUS AND DIPHTHERIA ONLY)  MMR (MEASLES, MUMPS, AND RUBELLA)  (REQUIRED FOR CHILD CARE ONLY)  HIB MENINGITIS (HAEMOPHILUS B)  HEPATITIS B  VARICELLA (CHICKENPOX)  TB Skin Test is  United Christian E  I have have not  Physician:  Address:	1st / / / / / / / / / / required ducation	e California I  2nd / / / / / / / / / / / / by  Center  above information Date	ATE EACH I	POSE WA	dian.	th / / /	/	/

LIC 701 (8/08) (Confidential) PAGE 1 OF 2

## **RISK FACTORS FOR TB IN CHILDREN:**

- \* Have a family member or contacts with a history of confirmed or suspected TB.
- \* Are in foreign-born families and from high-prevalence countries (Asia, Africa, Central and South America).
- Live in out-of-home placements.
- \* Have, or are suspected to have, HIV infection.
- \* Live with an adult with HIV seropositivity.
- \* Live with an adult who has been incarcerated in the last five years.
- \* Live among, or are frequently exposed to, individuals who are homeless, migrant farm workers, users of street drugs, or residents in nursing homes.
- Have abnormalities on chest X-ray suggestive of TB.
- Have clinical evidence of TB.

Consult with your local health department's TB control program on any aspects of TB prevention and treatment.

LIC 701 (8/08) (Confidential) PAGE 2 of 2