



**HEALTH CARE PROGRAM FOR CHILD CARE CENTERS
CHILD CARE CENTER HEALTH RECORD**

State Form 49969 (R4 / 2-15)

FSSA - MS02
402 WEST WASHINGTON STREET, RM W361
INDIANAPOLIS, IN 46204

Name of child (<i>last, first</i>)	Date of birth (<i>month, day, year</i>)	Date of admission (<i>month, day, year</i>)
Address (<i>number and street, city, state, and ZIP code</i>)		
Child lives with (<i>relationship</i>)	Name	Telephone number ()

MEDICAL HISTORY			
Communicable Disease	Month / Year	Condition	Explain if present
		Allergies:	-----
		Handicapping conditions:	-----
Screenings	Result / Date (<i>month, day, year</i>)	Other:	-----
TB Risk / Symptom			-----
Developmental Screen			-----
Lead			-----

PHYSICAL EXAMINATION	
Date of exam (<i>month, day, year</i>)	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 (<i>including sports</i>)? <input type="checkbox"/> Yes <input type="checkbox"/> 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: <input type="checkbox"/> Yes <input type="checkbox"/> No	

