

* DUE FIRST DAY OF CLASS *



PHYSICIAN'S REPORT (CHILD'S PRE-ADMISSION HEALTH EVALUATION)

PARENT'S CONSENT (TO BE COMPLETED BY PARENT)

_____, born _____ is being studied for readiness to enter
(NAME OF CHILD) (BIRTH DATE)

_____. City of Brea Tiny Tots provides a program which extends from _____ : _____
(NAME OF CHILD CARE CENTER/SCHOOL)
 a.m./p.m. to _____ a.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 City of Brea Tiny Tots.

(SIGNATURE OF PARENT, GUARDIAN, OR CHILD'S AUTHORIZED REPRESENTATIVE)

(TODAY'S DATE)

PHYSICIAN'S REPORT (TO BE COMPLETED BY PHYSICIAN)

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 a copy of California Immunization Record, PM-298)

VACCINE	DATE EACH DOSE WAS GIVEN				
	1st	2nd	3rd	4th	5th
POLIO (OPV OR IPV)	/ /	/ /	/ /	/ /	/ /
DTP/DTaP/ DT/Td <small>(DIPHTHERIA, TETANUS AND [ACELLULAR] PERTUSSIS OR TETANUS AND DIPHTHERIA ONLY)</small>	/ /	/ /	/ /	/ /	/ /
MMR <small>(MEASLES, MUMPS, AND RUBELLA)</small>	/ /	/ /	/ /	/ /	/ /
HIB MENINGITIS <small>(REQUIRED FOR CHILD CARE ONLY) (HAEMOPHILUS B)</small>	/ /	/ /	/ /	/ /	/ /
HEPATITIS B	/ /	/ /	/ /	/ /	/ /
VARICELLA <small>(CHICKENPOX)</small>	/ /	/ /	/ /	/ /	/ /

SCREENING OF TB RISK FACTORS (listing on reverse side)

- Risk factors not present; TB skin test not required.
- Risk factors present; Mantoux TB skin test performed (unless previous positive skin test documented).
 ___ Communicable TB disease not present.

I have have not reviewed the above information with the parent/guardian.

Physician: _____
 Address: _____
 Telephone: _____

Date of Physical Exam: _____
 Date This Form Completed: _____
 Signature _____

Physician Physician's Assistant Nurse Practitioner