## hysician's Signature Required This—rm must be returned by Septem—

STATE OF CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY CALIFORNIA DEPARTMENT OF SOCIAL SERVICES COMMUNITY CARE LICENSING

## PHYSICIAN'S REPORT—CHILD CARE CENTERS

(CHILD'S PRE-ADMISSION HEALTH EVALUATION)

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.    REGINAL JEE OF PARENT, GLIANDMAL OR CRIL-D'S AUPT-CRIZED REPRESENTATIVE) (TODAYS DATE)	This Child Care Center/School provides a program which extends from	7.11.1		2					BY PAREN				
This Child Care Center/School provides a program which extends from	This Child Care Center/School provides a program which extends from	(NAME OF CHILD)		, born		(BIRT	H DATE)	d)	is bein	g studied t	or readines	s to ente	
ANALYDATION	ALILYDIAN TO			This	s Child Ca	10.000	2012 C 4012001 C 201	nrovides	a program v	vhich 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 report to the above-named Child Care Center.    REGINAL JEE OF PARENT, GLIANDMAL OR CRIL-D'S AUPT-CRIZED REPRESENTATIVE) (TODAYS DATE)	Please provide a report on above-named child using the form below. I hereby authorize release of medical information contained i report to the above-named Child Care Center.    [BIGNALURE OF PAPERT, GLANGWAN, OR CRILO'S AUTHORIZED REPRESENDATIVE]	(NAME OF CHILD CARE CENTER/SCHO	OL)	1108	o.ma oa	0 001110	0011001	011403	- program v	on oxidi		· ·	
PART B — PHYSICIAN'S REPORT (TO BE COMPLETED BY PHYSICIAN)  PART B — PHYSICIAN'S REPORT (TO BE COMPLETED BY PHYSICIAN)  Problems of which you should be sware:  Hearing:  Allergies: medicine:  Hearing:  Allergies: medicine:	PART B - PHYSICIAN'S REPORT (TO BE COMPLETED BY PHYSICIAN)  Problems of which you should be sware:  Hearing:  Allergies: medicine:  Insert strings:  Developmental:  Language/Spaneth:  Commental: Spaneth:  Commental: Spaneth:  IMMUNIZATION HISTORY:  (Fill out or enclose California Immunization Record, PM-298.)  DATE EACH DOSE WAS GIVEN  VACCINE  DATE EACH DOSE WAS GIVEN  1st 2nd 3rd 4th 5th  POLICIO (DOY OR IPV)  // / / / / / / /  // / / / / / / /  // / / / / / /  // / / / / / / /  IMEDICATION FIRST RESIDENT RES	a.m./p.m. to a.m./p.m. ,	day:	s a week.									
PART B - PHYSICIAN'S REPORT (TO BE COMPLETED BY PHYSICIAN)  Problems of which you should be aware:  Hearing:  Allergies: medicine:  Insect strings:  Control of the control	PRATE B - PHYSICIAN'S REPORT (TO BE COMPLETED BY PHYSICIAN)  Problems of which you should be aware: Hearing:  Allergies: modeline: Insect stings:  Developmental:  Contract (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)  // / / / / / /  // / / /  // / / / /			ising the fo	orm belov	/. I hereb	y authori	ze releas	e of medica	al informati	on containe	ed in this	
Problems of which you should be aware:  Haaring:	Problems of which you should be aware:  Hearing:  Altergies: medicine:  Vision:    Insect stings:   Sood:   Languisge/Speech:   asthmat:   Other:   IMMUNIZATION HISTORY: (Fill out or enclose California Immunization Record, PM-298.)    VACCINE   DATE EACH DOSE WAS GIVEN     Texture   DATE EACH DOSE WAS GIVEN     OTHER   Other Personal Straws   Ot		(SI	GNATURE OF	PARENT, GUA	RDIAN, OR	CHILD'S AUTH	ORIZED REF	PRESENTATIVE)	1	(TODA)	('S DATE)	
Haaring:   Allergies:medicine:	Haaring: Allergies: medicine:  Vision: Insert stings:  Developmental: tood:  Language/Spaech: astlima: other:  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 (DPV OR IPV) / / / / / / / / / /  DIPPOTAPP (DEPHINERIA, ETANUS AND DIPPOTAPP) (DPHINERIA, ETANUS AND DIPPOTAPP) / / / / / / / / / / /  MARK (MEASLES, MUNIFS, AND RUBBLLA) / / / / / / / / / / /  HEPATITIS B / / / / / / / / / / / /  WARRICELLA (CHICKENPOX) / / / / / / / / /  WARRICELLA (CHICKENPOX) / / / / / / / / / /  PERATITIS B / / / / / / / / / / / / / / / / / /	PART B	- PHYS	SICIAN'S	REPO	RT (TO	ВЕ СОМ	PLETED	BY PHYSIC	CIAN)			
Vaccine   Insect strigs   Insect strigs	Valor:	Problems of which you should be aware:											
Developmental: food:  Language/Speech: asthma: other:  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) / / / / / / / / / / /  DTP/DTaP/ (DIPHTNERIA, TEXANUS AND AND EXPRESSION ONLY) / / / / / / / / / / / / / / / / / / /	Developmental: tood:  Language/Speech: asthma:	Hearing:			v manancas na	A	lergies: medi	cine:			<u> </u>		
Language/Speech:    Comments/Explanations:   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 (OPY OR IPY)  POLIO (OPY OR IPY)  DITTER AND PRESCRIBED/SPECIAL ROUTINES/RESTRICTIONS FOR THIS CHILD:  IMMUNIZATION HISTORY: (Fill out or enclose California Immunization Record, PM-298.)  DATE EACH DOSE WAS GIVEN  1st 2nd 3rd 4th 5th  follower of the permission on retains and properties of the permission of the	Vision:	# <u>###</u>			in	sect stings:	eren i	72 PAR 977 1076				
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(REQUIRED FOR CHILD CARE ONLY) HIB MENINGITIS (HAEMOPHILUS B)  HEPATITIS B  / / / / / / /  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.  Thave have not reviewed the above information with the parent/guardian.  Physician:  Address:  Date of Physical Exam:  Date This Form Completed:  Signature	(REQUIRED FOR CHILD CARE ONLY) HIB MENINGITIS (HAEMOPHILUS B)  / / / / / / /  HEPATITIS B  / / / / / /  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:  Date of Physical Exam:  Address:  Date This Form Completed:  Signature  Physician's Assistant Nurse Present.	DIP/DIAP/ [ACELLULAR] PERTUSSIS OR TETANUS	/	/	/	/	1	1	/	1	/	1	
HEPATITIS B / / / / / / / /  VARICELLA (CHICKENPOX) / / / / / / / / / / / / / / / / / / /	HEPATITIS B / / / / / / / / / / / / / / / / / /	MMR (MEASLES, MUMPS, AND RUBELLA)	1	1	1	1	8						
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