CHILD'S HEALTH STATUS FORM

Dear Physician:

The completion of this statement is necessary for this child to be cared for in a day care home.

Child's Name ________________________________ Sex ______ Birth Date ______

Address ____

Mother's or Guardian's Name ____

Father's or Guardian's Name ____

If tuberculin test given: Date ___________ Result _____________________

If chest x-rayed: Date ___________ Result _____________________

Surgery, accidents, illnesses, chronic or handicapping problems ________________

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Need for medication or special diets ______________________________________

Immunizations: Date of completed primary or latest booster

Type ______________ Date ____________ Type ______________ Date ________

Type ______________ Date ____________ Type ______________ Date ________

Physical findings (include, if tested, vision and hearing) _______________________

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Comments and recommendations to child care personnel _______________________

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Date ______________________ Doctor's Signature ________________________

Doctor's telephone number ________________________

Doctor's Address ________________________