

**PHYSICIAN'S REPORT – CHILD CARE CENTERS  
(CHILD'S PRE-ADMISSION HEALTH EVALUATION)**

DEPARTMENT OF SOCIAL SERVICES-COMMUNITY CARE LICENSE

**PART A – PARENT'S CONSENT (TO BE COMPLETED BY PARENT)**

\_\_\_\_\_ born \_\_\_\_\_ is being studied for readiness to enroll in  
(Name of child) (Birthdate)

\_\_\_\_\_. This Child Care Center/School 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 above-named Child Care Center.

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

\_\_\_\_\_  
(TODAY'S DATE)

**PART B – 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:
	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	1 <sup>ST</sup>	2 <sup>ND</sup>	3 <sup>RD</sup>	4 <sup>TH</sup>	5 <sup>TH</sup>
POLIO (OPV OR IPV)	/ /	/ /	/ /	/ /	/ /
DTP/DTaP/ (Diphtheria, Tetanus and acellular Pertussis or Tetanus And Diphtheria Only)	/ /	/ /	/ /	/ /	/ /
MMR (Measels, Mumps, and Rubella)	/ /	/ /			
HIB MENINGITIS (required for child care only) (Haemophilus B)	/ /	/ /	/ /	/ /	
HEPATITIS B	/ /	/ /	/ /		
VARICELLA (not required) (Chickenpox)	/ /	/ /			

**SCREENING OF TB RISK FACTORS** (listing on reverse side)