CHILD CARE CENTERS

MEDICAL RECORD

Dear Physician: *The child indicated below is enrolled in an early childhood program which is licensed by the Department of Early Education & Care. The Department of Early Education & Care requires the Medical History and Immunization form to be completed and signed by the physician or source of health care. A prompt response is appreciated.*

Evidence of a physical exam shall be valid for one year from the date the child was examined and shall be renewed annually thereafter.

IDENTIFICATION (To be completed by Parent/Guardian)

Name of Child: _____Date of Birth: _____
Child's Address: _____ Child's Home Phone: _____
City, State, and Zip Code: _____

Name of Parent/Guardian #1: _____
Address (include City, State, Zip): _____
Home Phone: _____ Work Phone: _____

Name of Parent/Guardian #2: _____
Address (include City, State, Zip): _____
Home Phone: _____ Work Phone: _____

EXAM/HEALTH INFORMATION (To be completed by Physician)

Date of Examination of Child: _____

What is your general opinion concerning the child's general health and appearance?

_____
_____
_____

Has this child been screened for lead poisoning? Yes _____ No _____

If yes, date screened: _____ ***Please note:*** *Lead Screenings are mandated for children between 9-12 months and annually thereafter until 48 months. Proof of any one of those screenings at entry to kindergarten is acceptable.*

Does this child have any disabilities or chronic medical problems (allergies, limited vision, etc.) which require special consideration or care by the day care provider? If so, please detail below:

_____
_____
_____

Physician's Signature: _____Date: _____

Massachusetts Department of Public Health

CERTIFICATE OF IMMUNIZATION

Name: _____

Date of Birth: / / **Sex:** □female □male

If combination vaccine is administered, please indicate vaccine type (e.g., DTaP-Hib, etc.)

Vaccine		Date/Vaccine Type	Vaccine		Date/Vaccine Type
Hepatitis B (e.g., HepB, HepB-Hib, DTaP-HepB-IPV)	1		***Haemophilus influenzae* type b** (e.g., Hib, HepB-Hib, DTaP-Hib)	1	
	2			2	
	3			3	
	4			4	
Diphtheria, Tetanus, Pertussis (e.g., DTaP, DT, DTaP-Hib, DTaP-HepB-IPV, Td, Tdap)	1		**Measles, Mumps, Rubella** (MMR)	1	
	2			2	
	3		**Varicella** (Var)	1	
	4			2	
	5		**Meningococcal** Conjugate (MCV4) or Polysaccharide (MPSV4)	1	
	6			2	
Polio (e.g., IPV, DTaP-HepB-IPV)	1		**Hepatitis A** (HepA)	1	
	2			2	
	3		**Pneumococcal Polysaccharide** (PPV23)	1	
	4			2	
	5		**Influenza** Inactivated (Intramuscular) or Live (Intranasal)	1	
Pneumococcal Conjugate (PCV7)	1			2	
	2			3	
	3		**Other:**		
	4				

Serologic Proof of Immunity		Check One	
Test (if done)	Date of Test	Positive	Negative
Measles	/ /		
Mumps	/ /		
Rubella	/ /		
Varicella*	/ /		
Hepatitis B	/ /		
* Must also check Chickenpox History box.			

Chickenpox History

□ Check the box if this person has a physician-certified reliable history of chickenpox.

Reliable history may be based on:

- physician interpretation of parent/guardian description of chickenpox
- physical diagnosis of chickenpox, or
- serologic proof of immunity

I certify that this immunization information was transferred from the above-named individual's medical records.

Doctor or nurse's name *(please print)*: **Date:** / /

Signature: _____

Facility name: _____