



MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
BUREAU OF CHILD CARE

MEDICAL EXAMINATION REPORT (INFANT/TODDLER & PRESCHOOL-AGE CHILD)

I. IDENTIFYING INFORMATION

PATIENT'S NAME	BIRTHDATE
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II. CURRENT STATE OF HEALTH

I HAVE EXAMINED THE ABOVE-NAMED CHILD AND VERIFY THAT THIS CHILD'S MEDICAL HISTORY AND CURRENT STATE OF HEALTH
 ARE ARE NOT SATISFACTORY FOR PARTICIPATION IN A CHILD CARE PROGRAM.

DOES THIS CHILD REQUIRE ANY SPECIALIZED CARE? YES NO
 IF YES, EXPLAIN IN SECTION IV.

III. IMMUNIZATION HISTORY

OUR RECORDS INDICATE THAT THIS CHILD HAS THE FOLLOWING IMMUNIZATIONS:

IMMUNIZATIONS	DATES GIVEN					
	Dose No. 1	Dose No. 2	Dose No. 3	Dose No. 4	Dose No. 5	Dose No. 6
_____ DPT/DT/DTAP						
_____ Polio						
_____ Hepatitis B						
_____ Hib						
_____ MMR						
_____ Varicella						

IV. COMMENTS/RECOMMENDATIONS

(SPECIAL DIETS, ALLERGIES, EAR INFECTIONS, CONVULSIONS, DIABETES, EMOTIONAL PROBLEMS)

SIGNATURE OF PHYSICIAN OR REGISTERED NURSE UNDER THE SUPERVISION OF A PHYSICIAN	DATE	PHYSICIAN'S OR NURSE'S NAME (PLEASE PRINT)
NAME OF CLINIC, GROUP PRACTICE, OTHER	IF NURSE IS SUPERVISED BY PHYSICIAN, INDICATE PHYSICIAN'S NAME	
ADDRESS (STREET, CITY, STATE, ZIP CODE)	TELEPHONE NUMBER ()	