MISSOURI DEPARTMENT OF HEALTH
BUREAU OF CHILD CARE & SAFETY LICENSURE

MEDICAL EXAMINATION REPORT (Infant/Toddler & Preschool-Age Child)

I. IDENTIFYING INFORMATION

PATIENT'S NAME **BIRTHDATE**

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.
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III. IMMUNIZATION HISTORY

OUR RECORDS INDICATE THAT THIS CHILD HAS THE FOLLOWING IMMUNIZATIONS:

	DOSE NO. 1	**DOSE NO. 2**	**DOSE NO. 3**	**DOSE NO. 4**	**DOSE NO. 5**	**DOSE NO. 6**
DPT/DT/DTAP						
POLIO						
HIB						
PCV (Pneumococcal)						
MMR						
HEPATITIS B						

DATE YOUR CHILD HAD CHICKEN POX _____

DATE YOUR CHILD HAD VARICELLA (CHICKENPOX) IMMUNIZATION _____

IV. COMMENTS/RECOMMENDATIONS

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

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SIGNATURE OF PHYSICIAN **DATE** **PHYSICIAN'S NAME (please print)**

_____ _____ _____

NAME OF CLINIC, GROUP PRACTICE, OTHER

_____

ADDRESS (STREET, CITY, STATE, ZIP CODE) **TELEPHONE NUMBER**

_____ _____