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:_____/_____/_____
Month day year

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 SATISFACTORY FOR PARTICIPATION IN A CHILD CARE PROGRAM.
  YES_____ NO_____
- DOES THIS CHILD REQUIRE ANY SPECIALIZED CARE? YES_____ NO_____
  IF YES, PLEASE EXPLAIN UNDER COMMENTS / RECOMMENDATIONS.

III. COMMENTS/RECOMMENDATIONS

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

_____

_____

_____

IV. 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						
IPV (Polio)						
HiB						
MMR						
HEPATITIS B						
PCV (Pneumococcal)						
Varicella (Chickenpox)						
COVID (NOT REQUIRED AT THIS TIME BUT PLEASE INDICATE DATES IF RECEIVED)						

PHYSICIAN'S SIGNATURE _____DATE _____

PHYSICIAN'S NAME (please print) _____

NAME OF CLINIC, GROUP PRACTICE, OTHER _____

STREET ADDRESS _____

CITY, STATE, ZIP CODE _____

TELEPHONE NUMBER _____