MISSOURI DEPARTMENT OF HEALTH
BUREAU OF CHILD CARE SAFETY & LICENSURE
MEDICAL EXAMINATION REPORT (INFANT/TODDLER & PRESCHOOL-AGE CHILD)

1 IDENTIFYING INFORMATION

PATIENT'S NAME	BIRTHDATE

11 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 DAY CARE PROGRAM.

DOES THIS CHILD REQUIRE ANY SPECIALIZED CARE? ☐ YES ☐ NO

III IMMUNIZATION HISTORY

OUR RECORDS INDICATE THAT THIS CHILD HAS THE FOLLOWING IMMUNIZATIONS:

IMMUNIZATIONS	DATES GIVEN					
	Dose No. 1	Dose No. 2	Does No. 3	Dose No. 4	Dose No. 5	Dose No. 6
_____DPT/DT						
_____Polio						
_____Hib						
_____MMR						
_____Hepatitis B						

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 NURSES NAME (PLEASE PRINT)
NAME OF CLINIC, GROUP PRACTICE, OTHER		IF NURSE IS SUPERVISED BY PHYSICIAN, INDICATE PHYSICIAN NAME
ADDRESS (STREET, CITY, STATE,ZIP CODE)		**TELEPHONE NUMBER** ( )

THIS REPORT IS TO BE KEPT ON FILE AT THE DAY CARE FACILITY