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HEALTH CARE PROGRAM FOR CHILD CARE CENTERS CHILD CARE CENTER HEALTH RECORD

State Form 49969 (R2 / 11-06) / BCC 0019

BUREAU OF CHILD CARE DIVISION OF FAMILY RESOURCES

Name of child (last, first)		Date of birth (month, day, year) Date of admission (month, day, year)										
Address (number and street, city, state, and Z	ldress (number and street, city, state, and ZIP code)											
Child lives with (relationship)	Name	Telephone number										
<u> </u>												
		L HISTORY										
Communicable Disease	Month / Year	Condition	Explain if present									
Measles		Allergies:										
Rubella (German Measles) Chickenpox		Handicapping conditions:										
Mumps		Haridicapping conditions.	 									
Scarlet Fever		Other:										
Whooping Cough												
Other:												
Date of exam (month, day, year)	PHYSICAL I	EXAMINATION Age of child										
bate of exam (month, day, year)		, igo oi oillia										
Skin		Heart	Ī									
Lymphnodes		Lungs										
Eyes		Abdomen										
Ears		Genitalia										
Nasopharynx Teeth and Mouth		Skeleton										
Note any unusual findings:		Other:										
Note any unusual infulligs.												
Does this child have any health condition that sports)?												
sports)? Yes No If Yes,	what modification of normal activities would	d be necessary to protect the child and the c	child's classmates:									
Have you prescribed any medications or spec	ial routines which should be included in the	center's plans for this child's activities? Eve	Nain.									
Yes No	iai routines willon should be included in the	Certier's plans for this critic's activities: Exp	лаш.									
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			HISTOR	RY OF IMMUNIZ	ATIONS AND TE	ST (indicate	month / da	y / year)	
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		<u> </u>	2	1		5	7		
	IPV (Polio)								
				_		_			
[1	2	3	4	5	-		
*	Influenza (Flu)								
[Magelae Mumne	1	2	-					
	Measles Mumps Rubella (MMR)			J					
		1	2	3	_				
	Rotavirus (RGE)				┚				
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	Mania alla	1	2	_		_Month /	vear		
	Varicella (Varivax)			or Chick	en Pox Disease	I I I I I I I I I I I I I I I I I I I	700.		
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	Pneumococcal (PCV) (Prevnar)								
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	HEPA								
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	HBV (HEP B)]				
	* Recommended	vearly.							
	me of physician / nur		mpleting form (please print)			Telephone nui	mber	
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Sig	nature of physician /	nurse practitione	r						
				ADDITIO	NAL NOTES AN	D INSTRUCT	TIONS		
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