Arthur M. Glick JCC
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Health Record (1)

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 ZIP code*)

Child lives with (*relationship*)	Name	Telephone number

MEDICAL HISTORY

Communicable Disease	Month / Year	Condition	Explain if present
Measles		Allergies:	
Rubella (German Measles)			
Chickenpox		Handicapping conditions:	
Mumps			
Scarlet Fever		Other:	
Whooping Cough			
Other:			

PHYSICAL EXAMINATION

Date of exam (*month, day, year*)		Age of child	
Skin		Heart	
Lymphnodes		Lungs	
Eyes		Abdomen	
Ears		Genitalia	
Nasopharynx		Skeleton	
Teeth and Mouth		Other:	

Note any unusual findings:

Does this child have any health condition that would be hazardous either to the child or to other children in a group setting as a result of participation in normal activities (*including sports*)? ☐ Yes ☐ No If Yes, what modification of normal activities would be necessary to protect the child and the child's classmates:

Have you prescribed any medications or special routines which should be included in the center's plans for this child's activities? Explain:

☐ Yes ☐ No

(*Over*)

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Health Record (2)

HISTORY OF IMMUNIZATIONS AND TEST (*indicate month / day / year*)

	1	2	3	4	5
DTaP / DT					

	1	2	3	4
Hib				

	1	2	3	4	5
IPV (Polio)					

	1	2	3	4	5
* Influenza (Flu)					

	1	2
Measles Mumps Rubella (MMR)		

	1	2	3
Rotavirus (RGE)			

	1	2		
Varicella (Varivax)			or Chicken Pox Disease	Month / year

	1	2	3	4
Pneumococcal (PCV) (Prevnar)				

	1	2
HEPA		

	1	2	3
HBV (HEP B)			

* Recommended yearly.

Name of physician / nurse practitioner completing form (*please print*)

Telephone number

Signature of physician / nurse practitioner

ADDITIONAL NOTES AND INSTRUCTIONS