KIDDIE ACADEMY
EDUCATIONAL CHILD CARE

Medical Statement of Child in Child Care

To Be Completed By Licensed Physician, Physician's Assistant, or Nurse Practitioner

Name of Child:	Date of Birth:

Immunizations Required For Entry Into Child Care

RECORD OF IMMUNIZATION

Or attach a copy of the child's current Immunization Record

DOSE NUMBER	DTaP MO/DAY/YR	HepB MO/DAY/YR	Hib MO/DAY/YR	MMR** MO/DAY/YR	PCV MO/DAY/YR	Polio MO/DAY/YR	Varicella MO/DAY/YR
1ST DOSE							
2ND DOSE							
3RD DOSE							
4TH DOSE							
5TH DOSE							

**Blood test verification of immunity and date may be entered in lieu of vaccination date.

Lead Screenings

Per NYS law, a blood lead test is required at 1 and 2 years of age and whenever risk of lead poisoning is likely. If the child has not been tested for lead, the day care provider may not exclude the child from child day care, but must give the parent information on lead poisoning and prevention, and refer the parent to their health care provider or the county health department for a blood screening test.

Lead Screening (Include all dates and results)

1 Year ___/___/____ Result: _____ mcg/dL ( ) Venous ( ) Capillary

2 Year ___/___/____ Result: _____ mcg/dL ( ) Venous ( ) Capillary

Most recent date of lead screening if different from above:

___/___/____ Result: _____ mcg/dL ( ) Venous ( ) Capillary

Health Specifics	Comments
Does the child have any allergies: ( ) Yes ( ) No	
Is medication regularly taken? ( ) Yes ( ) No	
Is there a special diet required? ( ) Yes ( ) No	
Are there any hearing, visual, or dental conditions requiring special attention? ( ) Yes ( ) No	
Are there any medical or developmental conditions requiring special attention? ( ) Yes ( ) No	
Summary of Exam (Include special recommendations to Child Care Providers)	

On the basis of my findings as indicated above and on my knowledge of the named child, I find that he/she is free from contagious and communicable disease and is able to participate in child care ( ) Yes ( ) No

_____
Date of Physical

Please stamp your company seal here:	Health Care Provider
	Signature of Examiner:
	Name Title Today's Date
	Phone: ( ) – Fax: ( ) –