# Geist Orchard Cooperative Preschool

## CHILD CARE/HEAD START HEALTH RECORD

Indiana State Form 23923 (R2/7-03)

***All child(ren's) physicals must be turned in no later than 30 days after their first day of enrollment. Please complete the Emergency Health Information and Plan form also.**

Child's Name _____ Birth Date _____/_____/_____
(Last) (First) Admission Date _____/_____/_____

Street Address _____ City _____ Zip _____

Child lives with _____ Name _____ Phone _____

### MEDICAL HISTORY

| Communicable Disease | Month/Year | Condition (Explain if present) |
|---|---|---|
| Measles | | Allergies: |
| Rubella (German Measles) | | |
| Chickenpox (Varicella) | | Physical Limitations: |
| Mumps | | |
| Scarlet Fever | | |
| Whooping Cough | | Other: |
| Hepatitis B | | |
| Other: | | |

### PHYSICAL EXAMINATION

Date of Exam _____ Age of Child _____

| | | | |
|---|---|---|---|
| Skin | | Heart | |
| Lymph nodes | | Lungs | |
| Eyes | | Abdomen | |
| Ears | | Genitalia | |
| Nasopharynx | | Skeleton | |
| Teeth & Mouth | | Other | |

Note any unusual findings: _____

Does this child have any health condition that would be hazardous to him/herself or to other children in a group setting as a result of participation in normal activities (including sports)? No _____ Yes _____. If "Yes", what modification of normal activities would be necessary to protect the child and his/her classmates? _____

Have you prescribed any medications or special routines which should be included in the center's plans for this child's activities?
No _____ Yes _____ Explain: _____

(Over)

HISTORY OF IMMUNIZATIONS (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 | | |
|---|---|---|---|---|
| Varicella (Varivax) | | | Or Chicken Pox Disease | Month/Year |

| | | |
|---|---|---|
| Measles Mumps Rubella (MMR) | | |

| | 1 | 2 | 3 |
|---|---|---|---|
| Rotavirus (RGE) | | | |

| | | | | |
|---|---|---|---|---|
| Pneumococcal (PCV) (Prevnar) | | | | |

| | 1 | 2 |
|---|---|---|
| HEPA | | |

| | 1 | 2 | 3 |
|---|---|---|---|
| HBV (HEP B) | | | |

Name of Physician Completing Form: _____ Phone Number: _____
(Please Print)

Physician's Signature: _____

ADDITIONAL NOTES AND INSTRUCTIONS