

PHYSICIAN'S MEDICAL REPORT

To Be Completed By Parent:

| | |
|--|------------------------|
| CHILD'S NAME | BIRTHDATE |
| PARENT'S NAME | |
| PHYSICIAN | |
| RETURN BY MAIL TO: CHILD'S DAY 2525 WALLINGWOOD DR #100 AUSTIN TX 78746 | OR FAX TO: 327-3281 |
| SIGNED | DATE |

To Be Completed By Physician:

| IMMUNIZATION DATES | | | | | |
|----------------------------|----|----|----|----|----|
| (Please show Mon/Day/Year) | | | | | |
| | #1 | #2 | #3 | #4 | #5 |
| DTaP | | | | | |
| POLIO | | | | | |
| PCV | | | | | |
| HiB CV | | | | | |
| Hep B | | | | | |
| Hep A | | | | | |
| MMR | | | | | |
| VARICELLA | | | | | |

| | | | | |
|---------|-------|---------|-------------------------------|-------------------------------|
| Tb TEST | DATE: | RESULT: | <input type="checkbox"/> pos. | <input type="checkbox"/> neg. |
| (OTHER) | | | | |

| |
|---|
| Are any restrictions on normal physical activities indicated? |
| Does any chronic medical condition necessitate dietary supplements, restrictions or medication? |
| Known allergies: |
| Date of last examination: |

We consider this child to be up-to-date on immunizations and able to participate in the child care center program at this time.

PHYSICIAN'S SIGNATURE _____ DATE ____/____/____