RETURN TO: First Presbyterian Children's Center - 100 E. Adams Ave. - Kirkwood, MO 63122

FAX # 314-965-3861

MEDICAL EXAMINATION REPORT (To be completed by physician or physician copy sent)

I. IDENTIFYING INFORMATION

PATIENT'S NAME	BIRTHDATE

II. CURRENT STATE OF HEALTH

I HAVE EXAMINED THE ABOVE-NAMED CHILD AND VERIFY THAT THIS CHILD'S MEDICAL HISTORY AND CURRENT STATE OF HEALTH ☐ ARE ☐ ARE NOT SATISFACTORY FOR PARTICITATION IN A DAY CARE PROGRAM.

DOES THIS CHILD REQUIRE ANY SPECIALIZED CARE? ☐ YES ☐ NO

IF YES, EXPLAIN IN SECTION IV.

III. IMMUNIZATION HISTORY

OUR RECORDS INDICATE THAT THIS CHILD HAS THE FOLLOWING IMMUNIZATIONS:

IMMUNIZATIONS	DATES GIVEN					
	Dose #1	Dose #2	Dose #3	Dose #4	Dose #5	Dose #6
________ DTaP/DT					////////////	////////////
________ IPV (Polio)					////////////	////////////
________ Hib					////////////	////////////
________ MMR		////////////	////////////	////////////	////////////	////////////
________ Hepatitis B					////////////	////////////
________ Varicella		////////////	////////////	////////////	////////////	////////////
________ PCV					////////////	////////////

IV. COMMENTS/RECOMMENDATIONS

(SPECIAL DIETS, ALLERGIES, EAR INFECTIONS, CONVULSIONS, DIABETES, EMOTIONAL PROBLEMS)

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SIGNATURE OF PHYSICIAN OR REGISTERED NURSE UNDER THE SUPERVISION OF A PHYSICIAN **(REQUIRED)**	DATE	PHYSICIAN'S OR NURSE'S NAME (PLEASE PRINT)

NAME OF CLINIC, GROUP PRACTICE, OTHER	IF NURSE IS SUPERVISED BY PHYSICIAN, INDICATE PHYSICIAN'S NAME

ADDRESS (STREET, CITY, STATE, ZIP CODE)	TELEPHONE NUMBER ( )