STATE OF CALIFORNIAZSAs

HEALTH AND HUMAN SERVICES AGENCY

**PHYSICIAN’S REPORT—CHILD CARE CENTERS**

(CHILD’S PRE-ADMISSION HEALTH EVALUATION)

CALIFORNIA DEPARTMENT OF SOCIAL SERVICES

COMMUNITY CARE LICENSING

**PART A – PARENT’S CONSENT (TO BE COMPLETED BY PARENT)**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, born \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ is being studied for readiness to enter

(NAME OF CHILD) (BIRTH DATE)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ . This Child Care Center/School provides a program which extends from \_\_\_\_\_ : \_\_\_\_

(NAME OF CHILD CARE CENTER/SCHOOL)

a.m./p.m. to \_\_\_\_\_\_ a.m./p.m. , \_\_\_\_\_\_\_\_\_\_ days a week.

Please provide a report on above-named child using the form below. I hereby authorize release of medical information contained in this report to the above-named Child Care Center.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(SIGNATURE OF PARENT, GUARDIAN, OR CHILD’S AUTHORIZED REPRESENTATIVE) (TODAY’S DATE)

**PART B – PHYSICIAN’S REPORT (TO BE COMPLETED BY PHYSICIAN)**

|  |  |
| --- | --- |
| Problems of which you should be aware: |  |
| Hearing: | Allergies:medicine: |
| Vision: | Insect stings: |
| Developmental: | Food: |
| Language/Speech: | Asthma: |
| Dental: |  |
| Other (Include behavioral concerns): |  |
| Comments/Explanations: |  |

MEDICATION PRESCRIBED/SPECIAL ROUTINES/RESTRICTIONS FOR THIS CHILD:

**IMMUNIZATION HISTORY:** (Enclose California Immunization Record, PM-298.)

|  |
| --- |
| **SCREENING OF TB RISK FACTORS** (listing on reverse side) Risk factors not present; TB skin test not required.  Risk factors present; Mantoux TB skin test performed (unless previous positive skin test documented).  \_\_\_ Communicable TB disease not present. |

I have have not reviewed the above information with the parent/guardian.

Physician:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Physical Exam: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date This Form Completed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Telephone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | Physician |  | Physician’s Assistant | Nurse Practitioner |

LIC 701 (8/08) (Confidential) PAGE 1 OF 2

**RISK FACTORS FOR TB IN CHILDREN:**

* Have a family member or contacts with a history of confirmed or suspected TB.
* Are in foreign-born families and from high-prevalence countries (Asia, Africa, Central and South America).
* Live in out-of-home placements.
* Have, or are suspected to have, HIV infection.
* Live with an adult with HIV seropositivity.
* Live with an adult who has been incarcerated in the last five years.
* Live among, or are frequently exposed to, individuals who are homeless, migrant farm workers, users of street drugs, or residents in nursing homes.
* Have abnormalities on chest X-ray suggestive of TB.
* Have clinical evidence of TB.

Consult with your local health department’s TB control program on any aspects of TB prevention and treatment.LIC 701 (8/08) (Confidential) PAGE 2 of 2