

FAMILY AND SOCIAL SERVICES ADMINISTRATION - MS02

402 W. Washington St., Room W362 Indianapolis, IN 46204

Name of child (<i>last, first</i>)		Date of birth (month, day, year)	Date of admission (month, day, year)			
Address (number and street, city, state, and	ZIP code)					
Child lives with (relationship)	Name		Telephone number			
			()			
		L HISTORY				
Communicable Disease	Month / Year	Condition	Explain if present			
		Allergies:				
		Handicapping conditions:				
Saraaninga	Pagult / Data (manth day year)	Handicapping conditions.				
Screenings TB Risk / Symptom	Result / Date (month, day, year)	Other:				
Developmental Screen						
Lead		7				
	PHYSICAL	EXAMINATION				
Date of exam (month, day, year)		Age of child				
Skin		Heart				
Lymphnodes		Lungs				
Eyes		Abdomen				
Ears		Genitalia				
Nasopharynx		Skeleton				
Teeth and Mouth		Other:				
Note any unusual findings:						
Does this child have any health condition that	would be hazardous either to the child or to oth	er children in a group setting as a result o	of participation in normal activities (including sports)?			
Yes No If Yes, what modificati	on of normal activities would be necessary to	protect the child and the child's classm	ates:			
Have you prescribed any modications or an	ecial routines which should be included in the	center's plans for this child's activities?	Evnlain:			
Yes No	oolar routines writer stidule de ilidiueu III lile	oomore piane for the offices activities?	Explain.			

1 2 DTaP / DT 1 2	3		
1 2		4	5
	3	4	
Hib			
1 2	3	4	5
IPV (Polio)			
1 2	3	4	5
	3	4	<u>5</u>
Influenza (Flu)			
12			
Measles Mumps			
Rubella (MMR)			
1 2	3		
Rotavirus (RGE)			
1 2			Month / yea
Varicella (Varivax) or	Chicken	Pox Disease	World / yea
1 2	3	4	
Pneumococcal (PCV) (Prevnar)			
1 2			
HEP A			
1 2	3		
HBV	<u> </u>		
(HEP B)			
* Recommended yearly. Jame of physician / nurse practitioner / physician assistant comple	eting form (please print)	
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