

PHYSICAL FORM FOR CHILD

State Form 49969 (R6 / 01-25)
FAMILY AND SOCIAL SERVICES ADMINISTRATION
OFFICE OF EARLY CHILDHOOD AND OUT-OF-SCHOOL LEARNING

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 ZI | P code) | | |
| Child lives with (relationship) | Name | | Telephone number |
| | | | |
| | MEDICA | L HISTORY | |
| Communicable Disease | Month / Year | Condition | Explain if present |
| | | Allergies: | |
| | | | |
| | | Handicapping conditions: | |
| Screenings | Result / Date (month, day, year) | | |
| TB Risk / Symptom | | Other: | |
| Developmental Screen | | _ | |
| Lead | | | |
| | | | |
| | PHYSICAL E | XAMINATION | |
| 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: | | | |
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| Does this child have any health condition that wo | ould be hazardous either to the child or to othe | er children in a group setting as a result of | participation in normal activities (including sports)? |
| | of normal activities would be necessary to | | |
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| | | | |
| Have you prescribed any medications or speci | al routines which should be included in the | center's plans for this child's activities? I | ±xplain: |
| Yes No | | | |
| | | | |
| | | | |
| | | | |
| | | | |

| 1 2 Measles Mumps Rubella (MMR) 1 2 3 Rotavirus (RGE) | DTaP / DT | | | | HISTORY | OF IMMUNIZA | ATIONS AND TE | :ST (Indicate n |
|--|--|----|------------------------|-------------------|--------------------|-------------------|----------------|-----------------|
| 1 | 1 | | | 1 | 2 | 3 | 4 | 5 |
| 1 | 1 | | DTaP / DT | | | | | |
| Hib | Hib | | | | | | | |
| 1 2 3 4 5 IPV (Polio) 1 2 3 4 5 * Influenza (Flu) 1 2 3 Measles Mumps Rubella (MMR) 1 2 3 Rotavirus (RGE) 1 2 3 Rotavirus (RGE) 1 2 3 4 Pneumococcal (Varivax) 1 2 3 4 Pheumococcal (PCV) (Prevnar) 1 2 3 4 Pheumococcal (PCV) (Prevnar) 1 2 3 4 PRecommended yearly. | 1 | | | 1 | 2 | 3 | 4 | |
| IPV (Polio) | IPV (Polio) | | Hib | | | | | |
| IPV (Polio) | IPV (Polio) | | | | | | | |
| 1 2 3 4 5 * Influenza (Flu) 1 2 Measles Mumps Rubella (MMR) 1 2 3 Rotavirus (RGE) 1 2 Varicella (Varivax) 1 2 3 4 Pneumococcal (PCV) (Prevnar) 1 2 3 4 Phep A 1 2 3 HBV (HEP B) * Recommended yearly. | 1 | | | 1 | 2 | 3 | 4 | 5 |
| 1 | 1 | | IPV (Polio) | | | | | |
| Influenza (Flu) | Influenza (Flu) 1 2 Measles Mumps Rubella (MMR) 1 2 3 Rotavirus (RGE) 1 2 Varicella (Varivax) 1 2 3 4 Pneumococcal (PCV) (Prevnar) 1 2 HEP A 1 2 3 HBV (HEP B) * Recommended yearly. Name of physician / nurse practitioner / physician assistant completing form (please print) | | | <u> </u> | | <u> </u> | | |
| 1 | 1 2 3 | | | 1 | 2 | 3 | 4 | 5 |
| Measles Mumps Rubella (MMR) 1 2 3 Rotavirus (RGE) 1 2 Varicella (Varivax) 1 2 3 4 Pneumococcal (PCV) (Prevnar) 1 2 HEP A 1 2 3 HBV (HEP B) * Recommended yearly. | Measles Mumps Rubella (MMR) 1 2 3 Rotavirus (RGE) 1 2 Varicella (Varivax) 1 2 3 4 Pneumococcal (PCV) (Prevnar) 1 2 HEP A 1 2 3 HBV (HEP B) * Recommended yearly. Name of physician / nurse practitioner / physician assistant completing form (please print) | * | Influenza (Flu) | | | | | |
| Measles Mumps Rubella (MMR) 1 2 3 Rotavirus (RGE) 1 2 Varicella (Varivax) 1 2 3 4 Pneumococcal (PCV) (Prevnar) 1 2 HEP A 1 2 3 HBV (HEP B) * Recommended yearly. | Measles Mumps Rubella (MMR) 1 2 3 Rotavirus (RGE) 1 2 Varicella (Varivax) 1 2 3 4 Pneumococcal (PCV) (Prevnar) 1 2 HEP A 1 2 3 HBV (HEP B) * Recommended yearly. Name of physician / nurse practitioner / physician assistant completing form (please print) | | | | | | | |
| The content of the | Rubella (MMR) 1 2 3 Rotavirus (RGE) 1 2 Varicella (Varivax) 1 2 3 4 Pneumococcal (PCV) (Prevnar) 1 2 HEP A 1 2 3 HBV (HEP B) * Recommended yearly. Name of physician / nurse practitioner / physician assistant completing form (please print) | | | | 2 | 7 | | |
| 1 2 3 Rotavirus (RGE) 1 2 Varicella (Varivax) 1 2 3 4 Pneumococcal (PCV) (Prevnar) 1 2 HEP A 1 2 3 HBV (HEP B) * Recommended yearly. | Rotavirus (RGE) 1 2 Varicella (Varivax) 1 2 3 4 Pneumococcal (PCV) (Prevnar) 1 2 HEP A 1 2 3 HBV (HEP B) * Recommended yearly. Name of physician / nurse practitioner / physician assistant completing form (please print) | | Measles Mumps | | | | | |
| Rotavirus (RGE) 1 2 Varicella (Varivax) 1 2 3 4 Pneumococcal (PCV) (Prevnar) 1 2 HEP A 1 2 3 HBV (HEP B) * Recommended yearly. | Rotavirus (RGE) 1 2 Varicella (Varivax) 1 2 3 4 Pneumococcal (PCV) (Prevnar) 1 2 HEP A 1 2 3 HBV (HEP B) * Recommended yearly. Name of physician / nurse practitioner / physician assistant completing form (please print) | | . tabolia (Millit) | <u> </u> | 1 | T | | |
| The state of the s | To Chicken Pox Disease Month / yes | | | 1 | 2 | 3 | 1 | |
| Varicella (Varivax) 1 2 3 4 Pneumococcal (PCV) (Prevnar) 1 2 HEP A 1 2 3 HBV (HEP B) * Recommended yearly. | Varicella (Varivax) 1 2 3 4 Pneumococcal (PCV) (Prevnar) 1 2 HEP A 1 2 3 HBV (HEP B) * Recommended yearly. Name of physician / nurse practitioner / physician assistant completing form (please print) | | Rotavirus (RGE) | | | | | |
| Varicella (Varivax) 1 2 3 4 Pneumococcal (PCV) (Prevnar) 1 2 HEP A 1 2 3 HBV (HEP B) * Recommended yearly. | Varicella (Varivax) 1 2 3 4 Pneumococcal (PCV) (Prevnar) 1 2 HEP A 1 2 3 HBV (HEP B) * Recommended yearly. Name of physician / nurse practitioner / physician assistant completing form (please print) | | | <u> </u> | | | I | |
| 1 | (Varivax) 1 2 3 4 Pneumococcal (PCV) (Prevnar) 1 2 HEP A 1 2 3 HBV (HEP B) * Recommended yearly. Name of physician / nurse practitioner / physician assistant completing form (please print) | | | 1 | 2 | 7 | | |
| 1 2 3 4 Pneumococcal (PCV) (Prevnar) 1 2 HEP A 1 2 3 HBV (HEP B) * Recommended yearly. | 1 2 3 4 Pneumococcal (PCV) (Prevnar) 1 2 HEP A 1 2 3 HBV (HEP B) * Recommended yearly. Name of physician / nurse practitioner / physician assistant completing form (please print) | | Varicella (Varivax) | | | or Chicker | n Pox Disease | Month / ye |
| Pneumococcal (PCV) (Prevnar) 1 2 HEP A 1 2 3 HBV (HEP B) * Recommended yearly. | Pneumococcal (PCV) (Prevnar) 1 2 HEP A 1 2 3 HBV (HEP B) * Recommended yearly. Name of physician / nurse practitioner / physician assistant completing form (please print) | | (Tailfax) | <u> </u> | | 1 | | |
| 1 2 HEP A 1 2 3 HBV (HEP B) * Recommended yearly. | T 2 HEP A 1 2 3 HBV (HEP B) * Recommended yearly. Name of physician / nurse practitioner / physician assistant completing form (please print) | | | 1 | 2 | 3 | 4 | |
| 1 2 HEP A 1 2 3 HBV (HEP B) * Recommended yearly. | 1 2 HEP A 1 2 3 HBV (HEP B) * Recommended yearly. Name of physician / nurse practitioner / physician assistant completing form (please print) | | Pneumococcal | | | | | |
| HEP A 1 2 3 HBV (HEP B) * Recommended yearly. | HEP A 1 2 3 HBV (HEP B) * Recommended yearly. Name of physician / nurse practitioner / physician assistant completing form (please print) | | (1 OV) (Flevilal) | <u> </u> | | | | |
| 1 2 3 HBV (HEP B) * Recommended yearly. | 1 2 3 HBV (HEP B) * Recommended yearly. Name of physician / nurse practitioner / physician assistant completing form (please print) | | | 1 | 2 | 7 | | |
| HBV (HEP B) * Recommended yearly. | * Recommended yearly. Name of physician / nurse practitioner / physician assistant completing form (please print) | | HEP A | | | | | |
| HBV (HEP B) * Recommended yearly. | * Recommended yearly. Name of physician / nurse practitioner / physician assistant completing form (please print) | | | <u> </u> | 1 | T | | |
| * Recommended yearly. | * Recommended yearly. Name of physician / nurse practitioner / physician assistant completing form (please print) | | | 1 | 2 | 3 | 1 | |
| * Recommended yearly. | * Recommended yearly. Name of physician / nurse practitioner / physician assistant completing form (please print) | | HBV (HEP B) | | | | | |
| Name of physician / nurse practitioner / physician assistant completing form (<i>please print</i>) | Name of physician / nurse practitioner / physician assistant completing form (<i>please print</i>) | | | vearly | | | I | |
| | | Va | me of physician / nurs | se practitioner / | physician assistan | t completing form | (please print) | |
| Signature of physician / nurse practitioner / physician assistant | | | | | | ABBITION | IAL NOTES AN | D INCTRUCTION |
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| Signature of physician / nurse practitioner / physician assistant ADDITIONAL NOTES AND INSTRUCTION | ADDITIONAL NOTES AND INSTRUCTION | | | | | | | |
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