Daycare Physical Form

Name_____ Birthdate_____

A. Medical History (to be completed by Parent)
   1. Is your child allergic to anything? No__ Yes__ If yes, what?_____
   2. Is your child currently under a doctor's care? No__ Yes__ If yes, for what?_____
   3. Is your child on any continuous medications? No__ Yes__ If yes, for what?_____
   4. Any previous hospitalizations or operations? No__ Yes__ If yes, for what?_____
      _____
   5. Any history of significant diseases or recurrent illnesses? No__ Yes__ If yes, what? _____
      _____
   6. Does your child have any physical or developmental disabilities? If so, please describe _____
      _____

   Signature of parent/guardian_____

B. Physical Exam (Performed by a licensed physician, or a certified Nurse Practioner meeting DEHNR standards for EPSDT program)

   Height_____ % Weight _____%
   Head____ Eyes_____Ears___Nose_____Teeth_____Throat_____Neck_____
   Heart___ Chest____Abd/GU___ Ext___ Neuro_____Skin___
   Should activities be limited? No___ Yes___ If yes, explain
   _____
   _____
   _____
   Any other recommendations?
   _____
   _____

   Signature of authorized examiner _____
   Date of exam_____