

MISSOURI DEPARTMENT OF HEALTH  
BUREAU OF CHILD CARE & SAFETY LICENSURE  
**MEDICAL EXAMINATION REPORT (Infant/Toddler & Preschool-Age Child)**

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**I. IDENTIFYING INFORMATION**

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PATIENT'S NAME

BIRTHDATE

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**II. CURRENT STATE OF HEALTH**

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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 PARTICIPATION IN A CHILD CARE PROGRAM.

DOES THIS CHILD REQUIRE ANY SPECIALIZED CARE? • YES • NO  
IF YES, EXPLAIN IN SECTION IV.

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**III. IMMUNIZATION HISTORY**

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OUR RECORDS INDICATE THAT THIS CHILD HAS THE FOLLOWING IMMUNIZATIONS:

	DOSE NO. 1	DOSE NO. 2	DOSE NO. 3	DOSE NO. 4	DOSE NO. 5	DOSE NO. 6
DPT/DT/DTAP						
POLIO						
HIB						
MMR						
HEPATITIS B						

DATE YOUR CHILD HAD CHICKEN POX \_\_\_\_\_

DATE YOUR CHILD HAD VARICELLA (CHICKENPOX) IMMUNIZATION \_\_\_\_\_

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**IV. COMMENTS/RECOMMENDATIONS**

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

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SIGNATURE OF PHYSICIAN

DATE

PHYSICIAN'S NAME (please print)

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NAME OF CLINIC, GROUP PRACTICE, OTHER

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ADDRESS (STREET, CITY, STATE, ZIP CODE)

TELEPHONE NUMBER

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