CENTER FOR EARLY EDUCATION AND CARE

University of Massachusetts Amherst 21 Clubhouse Drive Amherst, MA 01003

Phone: (413) 545-1566 Fax: (413) 545-0944

MEDICAL RECORD FORM

CHILD'S NAME:			Date of Birth:/ Sex: M			
Address:						
DATE OF PHYSICAL EXAM	l:/	/ year				
PHYSICIAN'S EXAMINATION Please record your findings after		mal; X = abnormal)				
BP/ Pulse		Lungs Spine	9			
Height Weight		Heart Rate	_ Rhythm Murmur			
Nutritional Status		Abdomen Ano-g	genital			
Diet Restrictions?	_	Lower Extremities	Range of motion			
Eyes Ears			Strength			
Nose Mouth			_ Range of motion			
Skin Teeth		Development				
Neck Throat COMMENTS / TREATMENT:		Gait Coo	rdination			
MEDICAL HISTORY (include Accidents	Heart Diseas	6e	Rheumatic Fever			
Allergy	Hernia		Rubella			
Asthma	Kidney Disea	ase	Scarlet Fever			
Congenital Anomaly	Measles		Tonsillitis			
Convulsions	Meningitis		Tuberculosis			
Diabetes	Mumps		Whooping Cough			
Ear Infection(s)	Pneumonia		Other:			
Encephalitis	Poliomyelitis	;	Other:			
CURRENT MEDICATION(S) SETTING:	AND/OR SPECIAL	NEEDS AND/OR LIMIT	TATIONS IN A GROUP (CHILD CAR	E	
Physician Name (please pr	int):		Date:			
Physician Signature:						
Facility Name and Address:						

RECORD OF IMMUNIZATIONS AND TESTS

CHILD'S NAME:			Date of Birth:/_	/_	Sex: M F
Please indicate vaccine da	te and	I type. If combination va	ccine, please indicate in each	n appl	icable section.
Vaccine		Date & Vaccine Type	Vaccine		Date & Vaccine Type
Dephtheria, Tetanus, Pertusis (DTP, DTaP, DTap-Hib, DTAaP-HepB-IPV, DTaP-IPV/Hib, Td, Tdap)	1		Hepatitis B (HepB, HepB-Hib, DTaP- HepB-IPV, HepA-HepB)	1	
	2			2	
	3			3	
	4			4	
	5		Varicella (Var, MMRV) *Reliable history of chickenpox may be based on: • Physician interpretation of	1	
Polio (IPV,DTaP-HepB-IPV, DTap-IPV/Hib)	1			2	
	2			*Check here if this person has a physician-certified reliable history of chickenpox	
	3		parent/guardian		
	4		description of chickenpoxPhysical diagnosis of		
Measles, Mumps,	1		chickenpox, or Serologic proof of immunity		
Rubella	2		Proumococcal	1	
(MMR, MMRV)	1		Pneumococcal Conjugate (PCV7)	2	
Haemophilus Influenzae type b (Hib, HepB-Hib, DTap-Hib, DTap-IPV/Hib)	2			3	
			_		
	3		Hamadida A	4	
	4		Hepatitis A (HepA, HepA-HepB)	1	
				2	
			Rotavirus	1	
			(RV5: 3-dose series, RV1: 2-dose series)	2	
LEAD SCREENING		ING		3	
			Influenza	1	
9 - 12 months 1			Inactivated (Itramuscular) or Live (Intranasal)	2	
2 - 2.11 years 2				3	
3 - 3.11 years 3				4	
4+ years 4 (if high risk city/town)				5	
(II TIIGHT HON ONLY TOWN)				6	
			nstances regarding the schedule		
Physician Name (please	print):	C	oate:_	
Physician Signature:					
Facility Name and Addre	ess:				