**First Trinity Preschool**
1570 Niagara Falls Blvd. Tonawanda, NY 14150
716.835.2220 FAX 716.833.6998

# Medical Statement of Child in Childcare

## To Be Completed By Physician, Physician's Assistant or Nurse Practitioner

| Name of Child: | Date of Birth: | Date of Examination: |
|---|---|---|
| | | |

## Immunizations

**Medical Exemption** The physical condition of the named child is such that one or more of the immunizations would endanger life or health. ☐ Yes ☐ No Attach certification specifying the exempt immunization(s).

| | | | | | |
|---|---|---|---|---|---|
| DPT / DT | 1st Date | 2nd Date | 3rd Date | Booster Date | Booster Date |
| Polio | 1st Date | 2nd Date | 3rd Date | Booster Date | Booster Date |
| Hib (conjugate preferred) | 1st Date | 2nd Date | 3rd Date | 4th Date | |
| Hepatitis B | 1st Date | 2nd Date | 3rd Date | | |
| MMR | 1st Date | 2nd Date | | | |
| Varicella / Chicken Pox | 1st Date | 2nd Date | | | |
| Pneumococcal (PCV 7) | 1st Date | 2nd Date | | | |

| **Other Immunizations** Type of Immunization: | Date: |
|---|---|
| Type of Immunization: | Date: |

## Tests

Tuberculin Test Date: _____ Mantoux Results: ☐ Positive ☐ Negative _____mm
If positive, or if x-ray ordered, attach physician's statement documenting treatment and follow-up.
Lead Screening Date: _____ Attach lead level statement

| Health Specifics | | Comments |
|---|---|---|
| Are there allergies? (Specify) | ☐ Yes ☐ No | |
| Is medication regularly taken? (Specify drug and condition) | ☐ Yes ☐ No | |
| Is a special diet required? (Specify diet and condition) | ☐ Yes ☐ No | |
| Are there any hearing, visual or dental conditions requiring special attention? | ☐ Yes ☐ No | |
| Are there any medical or developmental conditions requiring special attention? | ☐ Yes ☐ No | |

## Summary of Physical Exam

Include special recommendations to Childcare Providers

_____

_____

On the basis of my findings as indicated above and on my knowledge of the named child, I find that: he/she is free from contagious and communicable disease and is able to participate at First Trinity Preschool. ☐ Yes ☐ No

_____ _____
Signature of Examiner Address

_____ _____
Please Print Name City, State, Zip

_____ _____ _____
Title Phone Date