Medical Examination Report

For Ellisville United Methodist Church - Early Childhood Center
15977 Clayton Road, Ellisville, MO 63011 Fax #: 636-227-1494

Patient's Name: _____ Birthdate: _____

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 an early childhood program.

Does this child require any specialized care? _____
If yes, please explain

_____

_____

Immunizations:

Type	Dose No. 1 Date Received	Dose No. 2 Date Received	Dose No. 3 Date Received	Dose No.4 Date Received	Dose No. 5 Date Received	Signed Statement by parent indicating date of Chicken Pox Disease
DPT/DT						
Polio						
Hepatitis B						
Hib						
MMR						
Varicella						
Hepatitis A						

If a booster immunization is administered during the school year please have physician fill out the booster form in the Parent Orientation packet and return to the ECC office. **State Law requires children enrolled in our KDO/Preschool to have at least 4 DTP, 3 Polio, 1 MMR, 3 Hepatitis B, 1 or more HIB and 1 Varicella or signed statement by parent indicating their child has had a confirmed case of Chicken Pox.**

Comments and/or Recommendations:
Please list any special diets, allergies, asthma, ear infections, diabetes, convulsions, emotional problems.

_____

_____

_____ _____ _____

Signature of physician or RN (Required) **Date** Physician's or nurse's name (please print)

_____ _____

Name of clinic, group practice, other If a registered nurse, supervising physician

_____ _____

Address (Street, City, State, Zip) Phone