

**Medical Examination Report
For Living Word – Early Childhood Center
17315 Manchester Rd., Wildwood, MO 63038 Fax #: 636-821-2801**

Patient's Name: _____ Birth date: _____

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 the 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:

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)

Telephone