CHILD HEALTH RECORD

State of Connecticut
Department of Public Health
Child Day Care Licensing Program
1-800-282-6063; 1-800-439-0437

Child's Name_____ Date of Birth _____ Home Phone _____

Parents/Guardian _____ Address _____

IMMUNIZATION RECORD: (Month, Day, Year for each dose)

IMMUNIZATION	DATE					IMMUNIZATION	DATE
	1ST DOSE	2ND DOSE	3RD DOSE	4TH DOSE	5TH DOSE		
DTP/DTa/DT						MMR (1ST Dose)	
OPV/IPV						MEASLES (2nd Dose)	
Hib (HAEMOPHILUS INFLUENZA TYPE B)						VARICELLA (Chicken Pox) (Recommended)	
HEPATITIS B						OTHER (Specify)	

Are there medical contraindications to immunization for this child? ☐ Yes ☐ No

If yes, specify the vaccine(s) and indicate the contraindications specified in the vaccine manufacturers package insert that applies to this child: _____

Does this child have laboratory confirmed proof of immunity to natural infection? ☐ Yes ☐ No

If yes, please explain and attach laboratory report: _____

Is this child current or in progress with immunizations according to the schedule adopted by the Commissioner of Public Health? (Connecticut General Statute 19a-7f) ☐ Yes ☐ No

GENERAL HEALTH RECORD

Height _____ Weight _____ DATE OF EXAM:_____

Identify any known medical or emotional illness or disorder that would currently pose a risk to other children or which would currently affect the child's functional ability to participate safely in a day care setting: _____

_____

Medical information pertinent to routine child care and emergencies: _____

_____

Is this child taking prescription medication on a daily basis for a chronic illness/condition? ☐ Yes ☐ No

Does the child have allergies? ☐ Yes ☐ No Explain: _____

Is the child on a special diet:? ☐ Yes ☐ No Explain: _____

The next appointment for immunization is scheduled for: _____
(Required unless contraindicated, proof of immunity, or contrary to religious beliefs) (Month/Day/Year)

Medical Care Provider (Name, Address, Telephone #):

_____
Signature of MD, APRN, or PA

_____
Date Form Signed