



**CHILD'S PHYSICAL FOR ADMISSION
AND CONTINUED ATTENDANCE
IN A CHILD CARE CENTER**
6 WEEKS TO 6 YEARS OLD

Child's Name: _____ DOB _____

List past illnesses requiring medical attention: _____

List any surgeries, serious accidents, and special needs: _____

Allergies: _____

Does this child have any severe allergies? _____

Does this child need medications on a regular basis? _____

(If yes, you must fill out a health care plan)

If Tuberculin test given: Date _____ Result _____

Is this child in good mental and physical health and free of communicable diseases? YES NO (circle one)

This child may use sunscreen: YES NO (circle one)

Please record immunizations and dates administered on the Colorado Department of Health Certificate of Immunization form.

Are there any other concerns of which the teaching staff needs to be aware? _____



Signature of physician or nurse practitioner: _____

Name of physician or nurse practitioner: _____

Address: _____

City _____ State _____ Zip _____

Date: _____