GLENDALE COMMUNITY COLLEGE
CHILD DEVELOPMENT LABORATORY SCHOOL

PHYSICIAN'S REPORT

PARENT CONSENT:

_____born _____ is being assessed for readiness to enroll in the
(NAME OF CHILD) (BIRTH DATE)
Glendale Community College Child Development Center Laboratory School. The program requested is for _____hours per week. Activities include vigorous indoor and outdoor play with groups of children. The schedule includes breakfast and an afternoon snack, a lunch provided by the parents, and a nap.

*Please provide a report on above-named child using the form (below). I hereby authorize release of medical information contained in this report to Glendale Community College Child Development Center Laboratory School.

_____ _____
(SIGNATURE OF PARENT, GARDIAN, OR CHILD'S AUTHORIZED REPRESENTATIVE) (TODAY'S DATE)

PHYSICIAN'S REPORT (COMPLETED BY PHYSICIAN)

Wil you please provide following information/report on above named child:

Height_____ Weight_____ Abdomen_____
Genitalia_____ Posture_____ Skin & Scalp_____
Nervous System _____ Orthopedic_____ Ears_____
Endocrine Balance_____ Head_____ Nose_____
Eyes_____ Mouth & Throat_____ Lungs_____
Teeth_____ Gums_____ Lymph Glands_____
Chest_____ Heart_____

Nutritional Appearance_____

Behavior_____

The above named child is/is not physically and emotionally able to participate in the program described.
Comment:_____
_____
Medication prescribed or special routines which should be included in the center's plan for child's activities.
Comment:_____
Problems of which our child care should be aware: _____
Hearing: _____ Allergies: medicine: _____
Vision: _____ Insect sting: _____
Developmental: _____ Asthma: _____
Language/Speech: _____Dental: _____
Other (include behavioral concerns): _____
Comments/Explanations:
_____
MEDICATION PERSCRIBED/SPECIAL ROUTINES/RESTRICTIONS FOR THIS CHILD: _____
_____

IMMUNIZATION HISTORY:

Test & Immunization Records & Dates VACCINE *Required by State Law	DATES EACH DOSE WAS GIVEN				
	1ST	2ND	3RD	4TH	5TH
HIB MENINGITIS					
HEPATITIS B					
* POLIO (OPV or IPV)					
* DPT/DTaP/DT/Td (Diphtheria, Tetanus and [Acellular] Pertussis or Tetanus and Diphtheria Only)					
* MMR (Rubeola - 10 day, red measles, German measles - 3 day, Mumps					
*VAR (Varicella - Chicken Pox)					

SCREENING OF TB TEST FACTORS

❑ Risk factors not present; TB skin test not required.
❑ Risk factors present; Mantoux TB skin test performed
(unless previous positive skin test documented).
_____ Communicable TB disease not present.

I have ☐ have not ☐ reviewed the above information with the parent/guardian.

Physician:_____ Date of Physical Exam:_____

Address:_____ Date This Form Completed:_____

Telephone:_____ Signature_____

☐ Physical ☐ Physical Assistant ☐ Nurse Practitioner

RISK FACTORS FOR TB IN CHILDREN:

- Have a family member or contacts with a history of confirmed or suspected TB.
- Are in foreign-born families and from high-prevalence countries (Asia, Africa, Central and South America).
- Live in out-of-home placements.
- Have, or are suspected to have, HIV infection.
- Live with an adult with HIV seropositivity.
- Live with an adult who has been incarcerated in the last five years.
- Live among, or are frequently exposed to, individuals who are homeless, migrant farm workers, users of street drugs, or residents in nursing homes.
- Have abnormalities on chest X-ray suggestive of TB.
- Have clinical evidence of TB.

Consult with your local health department's TB control program on any aspects of TB prevention and treatment.