

NOAH'S ARK PRESCHOOL

1154 Great Plain Avenue Needham, MA 02492 781/449-2439

Medical History

Dear Physician: _____ is enrolled in an early childhood program which is licensed by the Department of Early Education and Care of the Commonwealth of Massachusetts. The EEC regulations require the Medical History and Immunization Form to be completed and signed by the child's physician or source of health care. A prompt response is appreciated.

Evidence of a physical exam shall be valid for one year from the date the child was examined and shall be renewed annually thereafter.

IDENTIFICATION

Name of Child: _____ Date of Birth: _____

Address: _____ Phone: _____

Name of Parent(s): _____

Address: _____

Date of Exam: _____

What is your opinion concerning the child's general health and appearance?

Has the child been screened for lead poisoning? _____

If yes, date of screening? _____

Does this child have any disabilities or chronic medical conditions which require special consideration or care by the preschool? If so, please describe below:

Additional Comments: _____

Physician's Signature: _____ Date: _____

CERTIFICATE OF IMMUNIZATION

Name: _____

Date of Birth: / /

Sex: M F

Please indicate vaccine type (e.g., DTaP-Hib, etc.)

Vaccine	Date	Vaccine Type	Vaccine	Date	Vaccine Type
Hepatitis B (e.g., HepB, HepB-Hib, DTaP-HepB-IPV, HepA-HepB)	1		Rotavirus (e.g., RV5: 3-dose series, RV1: 2-dose series)	1	
	2			2	
	3			3	
	4				
Diphtheria, Tetanus, Pertussis (e.g., DTP, DTaP, DT, DTaP-Hib, DTaP-HepB-IPV, DTaP-IPV/Hib, DTaP-IPV, Td, Tdap)	1		Measles, Mumps, Rubella (e.g., MMR, MMRV)	1	
	2			2	
	3		Varicella (e.g., Var, MMRV)	1	
	4			2	
	5		Meningococcal Conjugate (MCV4) or Polysaccharide (MPSV4)	1	
	6			2	
	7		Seasonal Influenza Inactivated (intramuscular) or Live (intranasal)	1	
		2			
Haemophilus influenzae type b (e.g., Hib, HepB-Hib, DTaP-Hib, DTaP- IPV/Hib)	1		H1N1 Influenza Inactivated (intramuscular) or Live (intranasal)	1	
	2			2	
	3			3	
	4			4	
Polio (e.g., IPV, DTaP-HepB-IPV, DTaP-IPV/Hib, DTaP-IPV)	1		Pneumococcal Polysaccharide (PPSV23)	1	
	2			2	
	3		Hepatitis A (e.g., HepA, HepA-HepB)	1	
	4			2	
	5		Human Papillomavirus (e.g., HPV quadrivalent, HPV bivalent.)	1	
		2			
Pneumococcal Conjugate (e.g., PCV7, PCV13)	1		Other:		
	2				
	3				
	4				

Serologic Proof of Immunity		Check One	
Test (if done)	Date of Test	Positive	Negative
Measles	/ /		
Mumps	/ /		
Rubella	/ /		
Varicella*	/ /		
Hepatitis B	/ /		

* Must also check Chickenpox History box.

Chickenpox History

Check the box if this person has a physician-certified reliable history of chickenpox.

Reliable history may be based on:

- physician interpretation of parent/guardian description of chickenpox
- physical diagnosis of chickenpox, or
- serologic proof of immunity

I certify that this immunization information was transferred from the above-named individual's medical records.

Doctor or nurse's name (please print): _____

Date: / /

Signature: _____

Facility name: _____