MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES BUREAU OF CHILD CARE



**CHILD MEDICAL EXAMINATION REPORT (INFANT/TODDLER/PRE-SCHOOL)**

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| --- | --- | --- | --- |
| **IDENTIFYING INFORMATION** | | | |
| CHILD’S NAME | | | BIRTHDATE |
| **CURRENT STATE OF HEALTH** | | | |
| Based on my assessment of this child’s medical history, current state of health and my physical examination of the child on / / , this child can participate in a child care program. This child has no special care needs unless specified below.  *(Date of medical examination must be within the last 12 months.)* | | | |
| **PHYSICIAN’S INSTRUCTIONS FOR SPECIALIZED CARE** | | | |
| Complete this section only if child requires special care at a child care facility, e.g. special diets, allergies, ear infections, convulsions, diabetes, asthma, behavior problems, hearing or visual impairment, etc. (Attach additional pages as needed.)  **Please return along with a copy of the child’s immunization record** | | | |
| SIGNATURE OF PHYSICIAN OR REGISTERED NURSE UNDER THE SUPERVISION OF A PHYSICIAN | | DATE | |
| PHYSICIAN’S OR NURSE’S NAME (PLEASE PRINT) | | | |
| NAME AND ADDRESS OF CLINIC, GROUP, PRACTICE OR OTHER (MAY USE STAMP.) | IF NURSE IS SUPERVISED BY A PHYSICIAN, INDICATE PHYSICIAN’S NAME (PLEASE PRINT.) | | |
| TELEPHONE NUMBER | | |

MO 580-1878 (12-06) TO BE FILED IN CHILD’S RECORD AT CHILD CARE FACILITY BCC-6A