

CHILD'S PHYSICAL FOR ADMISSION AND CONTINUED ATTENDANCE IN A CHILD CARE CENTER *6 weeks to 6 years old*
This form should be completed by medical staff.



Date _____

Child's Name _____ D.O.B _____

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 medication on a regular basis*? _____

If Tuberculin test given: Date _____ Neg. _____ Pos. _____

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.

Physician or Nurse Practitioner's Signature

Name of physician or nurse practitioner

Address and Phone Number