CHILD HEALTH LETTER

State Of Connecticut
Dept of Public Health
Child Day Care Licensing Program
1-800-282-6063; 1-800-439-0437

Child's Name___________________________________ Date of Birth_______________ Home Phone____________

Parents / Guardian________________________ Address____

IMMUNIZATION RECORD: (Month, Day, Year for each dose)

IMMUNIZATION DATE IMMUNIZATION DATE

	1ST	2ND	3RD	4TH	5TH		
DTP /DtaP/DT						**MMR (1st dose)**	
OPV / IPV						**MEASLES (2nd dose)**	
Hib Haemophilus Influenza TYPE B)						**VARICELLA (chicken pos) (Recommended)**	
HEPATITIS B						**OTHER (Specify)**	

Are there medical contraindication to immunization for this child? ( ) yes ( ) no
If yes, specify the vaccines(s) and indicate the contraindications specified in the vaccine manufactures package insert that applies to this child: ____
Does this child have laboratory confirmed proof of immunity to natural infection? () yes ( ) no
If yes, Please explain and attach laboratory report: ____
Is this child current or in progress with immunization according to the schedule adopted by the Commissioner of Public Health?
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(Connecticut General Statue 19a-7f)

GENERAL HEALTH RECORD

Height __________ Weight ____________________ DATE **OF EXAM; _______________________**

Identify any known medical or emotional illness or disorder that would currently pose a risk to other children or which would currently affects the child's functional ability to participate safely in a daycare setting: ______________________________

Medical Information pertinent to routine childcare and emergencies: ____

Is this child taking prescription medication on a daily basis for a chronic illness / condition? () YES ( ) NO
If yes, indicate prescription: ____

Does the child have allergies? ( ) yes ( ) no Explain____

Is the child on a special diet ( ) yes ( ) no Explain____

MEDICAL CARE PROVEDER (NAME, ADDRESS, TELEPHONE):

___________________________ Signature of MD, APRN or PA ___________________________**DATE**

PLEASE FAX TO WHIZ KIDS DAYCARE 860-589-1267