



TINY TOTS AND LITTLE TYKES, INC.
 PRESCHOOL CHILD CARE CENTER
 Established 1973



1200 Oakdale Ave.
 W. St. Paul, MN 55118
 651-457-0042
 Fax# 651-457-1633

HEALTH CARE SUMMARY

(to be completed and signed by physician)

Updated 04/09/07

Date of Enrollment _____

NAME OF CHILD _____ Birth Date _____

ADDRESS _____ Telephone _____

PARENT/S OR GUARDIAN _____

Date of last physical examination _____

How long have you been seeing this child? _____

Does this child have any allergies (including allergies to meds)? _____

Is a modified diet necessary? _____

Is any condition present that could result in an emergency? _____

What is the status of the child's Vision _____

Hearing _____

Speech _____

Please list below the important health problems.

Indicate if you or someone else is following the child for the problem, and check which problems require special attention at the center.

<u>Important Health Problems</u>	<u>Followed by you</u>	<u>Followed by other Med Source (Name)</u>	<u>Requires Special Attention at Center</u>
_____	_____	_____	_____
_____	_____	_____	_____

Other information helpful to the group child care center _____

(Physician Signature)

(Date)

(Source of Health Care)



Address _____

Please fax to 651-457-1633

This form must be filled out completely including the doctor's signature. We do need to have this form on or before the child's first day of attendance.

IMMUNIZATION HISTORY: Fill in the MO/DAY/YR information for children 2 months of age and older. Vaccines/doses in shaded boxes are not required by law. If child received a combined shot (like Hib-hep B), write the date in all the boxes that apply.

	Vaccine	Dose	MO	DAY	YR
Diphtheria, Tetanus, Pertussis (DTP) • 3 doses during 1st year (at 2-month intervals) • 4 th dose at 12-18 months • 5 th dose at 4-6 years or at school entrance <i>Indicate vaccine type: DTaP or DT.</i>		1			
		2			
		3			
		4			
		5			
Polio (IPV and/or OPV) • 3 doses at 2-18 months • 4 th dose at 4-6 years or at school entrance	Vaccine	Dose	MO	DAY	YR
		1			
		2			
		3			
Measles, Mumps, Rubella (MMR) • Required for children 15 months and older • Must be given on or after 1 st birthday • 2nd dose at 4-6 years	Vaccine	Dose	MO	DAY	YR
		1			
		2			
		4			
Haemophilus influenzae type b (Hib) • 3-4 doses for children at 2-15 months • 1 dose ≥12 months required • 1 dose for previously unvaccinated children 15-59 months • Not indicated for children 5 years or older	Vaccine	Dose	MO	DAY	YR
		1			
		2			
		3			
Varicella (Chickenpox) • 1 st dose between 12-18 months • 2 nd dose at 4-6 years or at school entrance	Vaccine	Dose	MO	DAY	YR
		1			
		2			
		2			
Disease Date:					
Pneumococcal Conjugate Vaccine (PCV) • 2-4 doses for children 2-24 months • Consider for unvaccinated children at 24-59 months in child care • Not indicated for children 5 years or older	Vaccine	Dose	MO	DAY	YR
		1			
		2			
		3			
Hepatitis B (Hep B) —required for kindergarten • 3 doses between birth and 18 months	Vaccine	Dose	MO	DAY	YR
		1			
		2			
		3			
Rotavirus • 3 doses at 2, 4, and 6 months	Vaccine	Dose	MO	DAY	YR
		1			
		2			
Influenza (LAIV or TIV) • 1 dose annually for children ≥6 months (1 st time influenza immunization requires 2 doses)	Vaccine	Dose	MO	DAY	YR
		1			
		2			
Hepatitis A (Hep A) • 2 doses separated by 6 months for children 12-24 months	Vaccine	Dose	MO	DAY	YR
		1			
		2			

Child Care Immunization Record

Must be on file before a child attends child care.

Name: _____
 Birthdate: _____ Date of Enrollment: _____
SIGNATURE(S) _____

A For children who are 15 months or older and who have received all the immunizations required by law for child care:
 I certify that the above-named child is at least 15 months of age and has completed the immunizations which are required by law for child care.
 Signature of Parent/Guardian or Physician/Public Clinic _____ Date _____

B For children who are younger than 15 months or who have not received all the immunizations required by law for child care:
 I certify that the above-named child has received the immunizations indicated to the left and:
 will complete the immunizations required by law for child care within 18 months; and/or
 immunization is not indicated for medical reasons or laboratory confirmation of adequate immunity exists for the following Immunization(s) _____ and/or
 the parent/guardian is opposed to certain vaccine(s) as indicated by them in Section C below.
 Signature of Physician or Public Clinic _____ Date _____

C If the parent/guardian conscientiously opposes immunizations:
 I hereby certify by notarization that:
 I am opposed to all immunizations.
 I am opposed to only the vaccines indicated and have had my physician or health care provider complete Section B above. Vaccine(s) I oppose are: _____

Signature of Parent/Guardian _____ Date _____
 Subscribed and sworn to before me this _____ day of _____, 20____
 Signature of Notary Public (A copy of the notarized statement will be forwarded to the commissioner of health.)

Notary Public Stamp
