PRESCHOOL HEALTH RECORD

Emmanuel Lutheran Early Childhood Ministry
917 West Jefferson Boulevard - Fort Wayne, Indiana 46802-4007
(260) 423-1369 - Fax # 426-6147 - https://www.emmanuellutheran.org

Date _____

This report is to be completed by a Licensed Physician, Physician's Assistant or Nurse Practitioner who has seen the child within the last 3 months. We need this form returned BEFORE your child's first day of attendance.

Child's Name _____ **Sex** _____

Birth Date _____

HISTORY OF VACCINES

To be considered adequately protected, a child of age 18 months or older should have received:

- **at least four DTaP vaccines**
- **Varicella (Chicken Pox) vaccine (Mandatory)**
- **at least three Polio vaccines**
- **Hepatitis B**
- **vaccines against Measles, Mumps and Rubella**

It is also recommended that children under the age of five years receive the:

- **HIB (Haemophilus Influenzae) vaccine**
- **RGE (Rotavirus) vaccine**

Vaccines	Month/Year Given	Month/Year Given	Month/Year Given	Month/Year Given	Month/Year Given
DTaP	1	2	3	4	5
IPV (Polio)	1	2	3	4	5
HBV (HEP B)	1	2	3	4	5
MMR (Measles, Mumps, Rubella)	1	2	3	4	5
Varicella (Chicken Pox)	1	2	3	4	5
HIB	1	2	3	4	5
PCV (Prevnar)	1	2	3	4	5
HEP A	1	2	3	4	5

(OVER)

Preschool Health / Vaccine Record

Emmanuel Lutheran Early Childhood Ministry

Child's Name _____

This child _____IS _____IS NOT physically or emotionally able to participate in the preschool / daycare program named above.

Comments: _____

_____

Surgery / accidents / illness / chronic or physical disabilities: _____

_____

Describe any physical condition requiring special attention by staff: _____

_____

Medication(s) prescribed: _____

_____

Allergies (Food and/or Medication) that staff should be aware of: _____

_____

Prescribed routine for allergy treatment: _____

_____

Date of my most recent examination of child: _____

X _____

Signature of Licensed Physician, Physician's Assistant or Nurse Practitioner **Date**

_____ _____

Printed name of Physician, Physician's Assistant or Nurse Practitioner **Office Phone Number**

_____

Address