NOAH'S ARK PRESCHOOL

1154 Great Plain Avenue Needham, MA 02492 781/449-2439

Medical History

Dear Physician: _____ is enrolled in an early childhood program which is licensed by the Department of Early Education and Care of the Commonwealth of Massachusetts. The EEC regulations require the Medical History and Immunization Form to be completed and signed by the child's physician or source of health care. Please note that the SCHOOL/CAMP HEALTH RECORD FORM generated by your office can be used in lieu of filling out this form.

Evidence of a physical exam shall be valid for one year from the date the child was examined and shall be renewed annually thereafter. Evidence that the child has been screened for lead poisoning must be included on the form.

IDENTIFICATION

Name of Child: _____ Date of Birth: _____

Address: _____ Phone: _____

Name of Parent(s): _____

Address: _____

Date of Exam: _____

What is your opinion concerning the child's general health and appearance?

_____
_____
_____

Has the child been screened for lead poisoning? _____

If yes, date of screening? _____

Does this child have any disabilities or chronic medical conditions which require special consideration or care by the preschool? If so, please describe below:

_____
_____
_____

Additional Comments: _____
_____
_____

Physician's Signature: _____ Date: _____

CERTIFICATE OF IMMUNIZATION

Name: **Date of Birth:** / / **Sex:** M F

Please indicate vaccine type (e.g., DTaP-Hib, etc.)

Vaccine		Date	Vaccine Type
Hepatitis B (e.g., HepB, HepB-Hib, DTaP-HepB-IPV, HepA-HepB)	1		
	2		
	3		
	4		
Diphtheria, Tetanus, Pertussis (e.g., DTP, DTaP, DT, DTaP-Hib, DTaP-HepB-IPV, DTaP-IPV/Hib, DTaP-IPV, Td, Tdap)	1		
	2		
	3		
	4		
	5		
	6		
	7		
***Haemophilus influenzae* type b** (e.g., Hib, HepB-Hib, DTaP-Hib, DTaP-IPV/Hib)	1		
	2		
	3		
	4		
Polio (e.g., IPV, DTaP-HepB-IPV, DTaP-IPV/Hib, DTaP-IPV)	1		
	2		
	3		
	4		
	5		
Pneumococcal Conjugate (e.g., PCV7, PCV13)	1		
	2		
	3		
	4		

Vaccine		Date	Vaccine Type
Rotavirus (e.g., RV5: 3-dose series, RV1: 2-dose series)	1		
	2		
	3		
Measles, Mumps, Rubella (e.g., MMR, MMRV)	1		
	2		
Varicella (e.g., Var, MMRV)	1		
	2		
Meningococcal Conjugate (MCV4) or Polysaccharide (MPSV4)	1		
	2		
Seasonal Influenza Inactivated (Intramuscular) or Live (Intranasal)	1		
	2		
	3		
	4		
H1N1 Influenza Inactivated (Intramuscular) or Live (Intranasal)	1		
	2		
Pneumococcal Polysaccharide (PPSV23)	1		
	2		
Hepatitis A (e.g., HepA, HepA-HepB)	1		
	2		
Human Papillomavirus (e.g., HPV quadrivalent, HPV bivalent,)	1		
	2		
	3		
Other:			

Serologic Proof of Immunity		Check One	
Test (if done)	Date of Test	Positive	Negative
Measles	/ /		
Mumps	/ /		
Rubella	/ /		
Varicella*	/ /		
Hepatitis B	/ /		
* Must also check Chickenpox History box.			

Chickenpox History

☐ Check the box if this person has a physician-certified reliable history of chickenpox.

Reliable history may be based on:

- physician interpretation of parent/guardian description of chickenpox
- physical diagnosis of chickenpox, or
- serologic proof of immunity

I certify that this immunization information was transferred from the above-named individual's medical records.

Doctor or nurse's name *(please print)*: **Date:** / /

Signature:

Facility name: