Division of Early Care and Education DCF-F (CFS-0060) (R.12/2008)

CHILD HEALTH REPORT - CHILD CARE CENTERS

Use of form: Use of this form is mandatory to comply with DCF 250.07(6)(L)3. and DCF 251.07(6)(k)3. It also meets the requirements of DCF 202.08(4). Failure to comply may result in issuance of a noncompliance statement. Personally identifiable information gathered on this form will be used only to verify compliance with licensing rules.

Instructions: Each child under 2 years of age shall have an initial health examination not more than 6 months prior to nor later than 3 months after being admitted to the center and a follow-up health examination at least once every 6 months after admission. Except for a school-aged child, each child 2 years of age or older shall have an initial health examination not more than one year prior to nor later than 3 months after being admitted to a center and a follow-up health examination at least once every 2 years after admission.

PARENT OR GUARDIAN – Complete this section.		
Name – Child (Last, First, MI)		Birthdate - Child (mm/dd/yyyy)
Name - Child (Last, First, Wil)		Bittidate - Child (Hill/dd/yyyy)
Address - Child (Street, City, State, Zip Code)		
Name Derent or Cuardian (Last First MI)		
Name – Parent or Guardian (Last, First, MI)		
Address – Parent or Guardian (Street, City, State, Zip Code)		
HEALTH PROFESSIONAL – Complete this section.		
Instructions for feeding and care of child with special problems, including allergies – Specify.		
Data of wood was not blood band took	and did to a second state of the second	o Maratinatal and associated to be tracted at
Date of most recent blood lead test: (mm/dd/yyyy). Note: Children on Medicaid are required to be tested at		
around ages 12 months and 24 months or once between the ages of 3 and 5 years if no previous test is documented. Lead testing is optional		
for children who are not on Medicaid.		
Immunization(s) not to be administered to child due to medical reason(s) – Specify.		
AUTHORIZATION		
AUTHORIZATION		
I certify that I have examined the above child on this date and that he / she is able to participate in child care activities.		
Name – MD, PA or HealthCheck Provider (type or print) Address (Street, City, State, Zip Code)		
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SIGNATURE - MD, PA or HealthCheck Provider		Date of Examination