

**LITTLE TOTS II TEEN
1160 POST ROAD WARWICK, R.I. 02888
(401) 781-1870**

DEAR PARENT OR GUARDIAN,

IN ORDER FOR ANY CHILD TO ATTEND ANY DAYCARE CENTER IN RHODE ISLAND, IT IS MANDATED THAT A PHYSICIAN'S RECORD OF IMMUNIZATION AND PRE-ADMISSION EXAMINATION BE PROVIDED TO DAY CARE CENTER OFFICIALS.

PLEASE HAVE THE ATTACHED FORM COMPLETED BY YOUR PHYSICIAN AND RETURN THIS FORM TO THE DAY CARE CENTER PRIOR TO YOUR CHILD'S START DATE.

IN ADDITION, WOULD YOU RESPOND TO THE QUESTIONS LISTED BELOW CONCERNING YOUR CHILD.

PLEASE SIGN AND DATE THIS PAGE AND RETURN IT TO THE DAY CARE CENTER. THANK YOU.

CHILD'S NAME: _____

HAS YOUR CHILD HAD A TUBERCULIN SKIN TEST? YES _____ NO _____

IF YES, INDICATE: DATE: _____ POSITIVE: _____ NEGATIVE: _____

HAS YOUR CHILD HAD A LEAD SCREENING TEST? YES _____ NO _____

IF YES, INDICATE: DATE: _____ POSITIVE: _____ NEGATIVE: _____

HAS YOUR CHILD EVER VISITED A DENTIST OR DENTAL CLINIC? YES _____ NO _____

ARE THERE ANY CONDITIONS WHICH SHOULD BE BROUGHT TO THE ATTENTION OF THE DIRECTOR, A TEACHER AND/OR

NURSE IN THE CENTER, E.G., ALLERGIES, SEIZURES, SURGERY, ETC.? YES _____ NO _____

PLEASE SPECIFY: _____

**CHILD DAY CARE CENTER
 PREADMISSION IMMUNIZATION RECORD AND HEALTH EXAMINATION**

Child's Name: _____ DOB: _____

Address: _____

VACCINE	MONTH/DAY/YEAR ADMINISTERED				
DTP					
POLIO					
MMR					
Hib					
HB					

- DTP: = Diphtheria, Tetanus, Pertussis
- MMR: = Measles, Mumps, Rubella (second dose required before 13 years of age or entry to 7th grade.)
- Hib: = Haemophilus b Conjugate Vaccine (Hib vaccine is given as either a 4 dose schedule or a 3 dose schedule, depending on the type of vaccine used).
- HBV: = Hepatitis B Vaccine. (recommended)

Tuberculin skin test: Date: _____ Results: _____

Lead screening test: Date: _____ Rescreening Required: Yes _____ No _____

Date of Rescreening: _____

Health examination: Date: _____ Results: _____

Does the child have any conditions or limitations which a caregiver should be aware of, such as allergies, seizures, etc.? Yes _____ No _____

Please specify: _____

DATE

SIGNATURE OF PHYSICIAN