The Purpose School

1 Church St
Stoneham, MA 02180
Fax: 781-438-0238

Health Record

Date Filled Out:_____Date of Physical Exam:_____

GROUP CHILD CARE MEDICAL EXAMIMATION

(To be completed by Health Care Provider)

Child Information:

Name:

Address:

Findings:

Please state any necessary modifications to the child's program for health reasons. If none, please indicate this.

Dear Physician:
Our center requires that children's immunizations be current and that evidence of such is on file at the center. Parents must return this form to us indicating which immunizations the child has received.

_____ _____
Child's Name Date of Birth

Certificate of Immunizations

Vaccine						
Check Appropriate Box				DATE	Health Care Provider's Signature	Date of Next Immunization
STP	**DT**	**Td**				
			1			
			2			
			3			
			4			
			5			
			6			
POLIO			1			
			2			
			3			
			4			
MMR			1			
			2			
Hib			1			
			2			
			3			
			4			
Hep B			1			
			2			
			3			
Lead Screening						
Chicken Pox Vaccine						
Other						