

**FAIR ACRES
COUNTRY DAY SCHOOL**

35 FAIR ACRES DR., MARSTONS MILLS, MA 02648
PH (508) 420-3288
FAX (508) 420-1710
www.fairacrescapecod.com

Physical Form

Dear Physician: _____ in enrolled in an early childhood program which is licensed by the Department of Early Education and Care. The Department of Early Education and Care regulations require that the Medical History and Immunizations Form be completed and signed by the child's physician or source of health care. A prompt response is appreciated.

Evidence of a physical exam is valid for one year from the date the child was examined and must be renewed annually thereafter.

IDENTIFICATION

Name of child _____ DOB _____
Address _____ Phone _____
Name of Parents _____
Address _____

Date of Examination of Child _____

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

Has this child been **screen for lead** poisoning? Yes _____ No _____
If Yes, date screened _____

Does this child have any disabilities or chronic medical problems (allergies, limited vision, etc.) which require special consideration or care by the school or day care provider? If so, please detail below:

Physician's Signature _____ **Date** _____
Comments: _____

Please return to: FAIR ACRES COUNTRY DAY SCHOOL
35 FAIR ACRES DRIVE
MARSTONS MILLS, MA 02648
Massachusetts Department of Public Health

CERTIFICATE OF IMMUNIZATIONS

Name _____

Date of Birth _____ Sex: female or male _____

Vaccine Date

Hepatitis B 1 _____
 2 _____
 3 _____

DTaP DTP DT _____
 1 _____
 2 _____
 3 _____
 4 _____
 5 _____

IPV OPV _____
 1 _____
 2 _____
 3 _____
 4 _____

Vaccine Date

Hib 1 _____
 2 _____
 3 _____
 4 _____

MMR 1 _____
 2 _____

Varicella 1 _____
 2 _____

Other _____

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

Facility Name: _____

Doctor or Nurse Name (please print): _____

Signature: _____ Date _____