

**MUST BE COMPLETED BY YOUR DOCTOR - DUE BEFORE 8/3/19**

**PHYSICIAN'S REPORT—CHILD CARE CENTERS**  
(CHILD'S PRE-ADMISSION HEALTH EVALUATION)

**PART A – PARENT'S CONSENT (TO BE COMPLETED BY PARENT)**

\_\_\_\_\_, born \_\_\_\_\_ is being studied for readiness to enter  
(NAME OF CHILD) (BIRTH DATE)

RBCPC Preschol \_\_\_\_\_ . This Child Care Center/School provides a program which extends from \_\_\_\_\_ : \_\_\_\_\_  
(NAME OF CHILD CARE CENTER/SCHOOL)

a.m./p.m. to \_\_\_\_\_ a.m./p.m. , \_\_\_\_\_ days a week.

Please provide a report on above-named child using the form below. I hereby authorize release of medical information contained in this report to the above-named Child Care Center.

\_\_\_\_\_  
(SIGNATURE OF PARENT/DOMESTIC PARTNER, GUARDIAN, OR CHILD'S AUTHORIZED REPRESENTATIVE)

\_\_\_\_\_  
(TODAY'S DATE)

**PART B – PHYSICIAN'S REPORT (TO BE COMPLETED BY PHYSICIAN)**

Problems of which you should be aware:

Hearing: \_\_\_\_\_ Allergies: medicine: \_\_\_\_\_

Vision: \_\_\_\_\_ Insect stings: \_\_\_\_\_

Developmental: \_\_\_\_\_ Food: \_\_\_\_\_

Language/Speech: \_\_\_\_\_ Asthma: \_\_\_\_\_

Dental: \_\_\_\_\_

Other (Include behavioral concerns): \_\_\_\_\_

Comments/Explanations: \_\_\_\_\_

MEDICATION PRESCRIBED/SPECIAL ROUTINES/RESTRICTIONS FOR THIS CHILD: \_\_\_\_\_

**IMMUNIZATION HISTORY:** (Fill out or enclose California Immunization Record, PM-298.)

VACCINE	DATE EACH DOSE WAS GIVEN				
	1st	2nd	3rd	4th	5th
POLIO (OPV OR IPV)	/ /	/ /	/ /	/ /	/ /
DTP/DTaP/ DT/d (DIPHTHERIA, TETANUS AND [ACELLULAR] PERTUSSIS OR TETANUS AND DIPHTHERIA ONLY)	/ /	/ /	/ /	/ /	/ /
MMR (MEASLES, MUMPS, AND RUBELLA)	/ /	/ /			
(REQUIRED FOR CHILD CARE ONLY)					
HIB MENINGITIS (HAEMOPHILUS B)	/ /	/ /	/ /	/ /	
HEPATITIS B	/ /	/ /	/ /		
VARICELLA (CHICKENPOX)	/ /	/ /			

**SCREENING OF TB RISK FACTORS** (listing on reverse side)

Risk factors not present; TB skin test not required.

Risk factors present; Mantoux TB skin test performed (unless previous positive skin test documented).  
 \_\_\_ Communicable TB disease not present.

I have  have not  reviewed the above information with the parent/guardian.

Physician: \_\_\_\_\_  
Address: \_\_\_\_\_  
Telephone: \_\_\_\_\_

Date of Physical Exam: \_\_\_\_\_  
Date This Form Completed: \_\_\_\_\_  
Signature \_\_\_\_\_

Physician  Physician's Assistant  Nurse Practitioner

# RBCPC PRESCHOOL 2019-2020

TO OPT OUT OF THIS TEST, PLEASE MARK THE BOX THAT APPLIES.

My child did this test last year and RBCPC Preschool has it on file.

I decline this test for religious/personal reasons. \_\_\_\_\_  
*Parent signature* *date*

## CHILD BLOOD LEAD TEST COMPLIANCE FORM

In accordance with Section 54.1011 of the City of San Diego's Lead Hazard Prevention and Control Ordinance (effective May 9, 2008), all child care centers or employee operated child-care centers in the City of San Diego are required to collect evidence of a blood lead test for each new enrollment for children between the ages of six months and seven years of age inclusive. Proof of blood lead screening is to be provided prior to admission, but in no event later than thirty days after admission. Please use this form to have your physician verify the test was completed, and return it to our office.

A blood lead test can be conducted by your current health care provider, either using a capillary (finger prick) test or a blood draw. You can discuss with your physician the types of test they perform. Physicians who are interested in getting trained in the capillary draw method can contact the County Health Department at (619) 515-6576, or at (619) 515-6636. Costs for these tests are typically covered by most health care insurances. If you would like a listing of clinics that conduct finger prick testing, or more information about the ordinance and childhood lead poisoning prevention, visit the City of San Diego's Lead Safety and Healthy Homes Program website at [www.sdhealthyhomes.org](http://www.sdhealthyhomes.org), or call (858) 694-7000.

Parent or legal guardian: \_\_\_\_\_  
*Print Name*

Address: \_\_\_\_\_  
*Street City Zip*

Child's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

### Physician use only

On \_\_\_\_\_ the above listed child was screened for lead poisoning  
*Date*  
in accordance with applicable criteria mandated by the State of California.

Physician: \_\_\_\_\_  
*Print Name*

\_\_\_\_\_  
*Physician's Signature Date Phone#*

Childhood lead poisoning is the greatest **preventable** environmental disease affecting children today. The highest risk is for children under six as their brains and nervous systems are still developing and are more sensitive to the damaging effects of lead. Medical research has shown there is no safe level of lead exposure in children and the effects of lead exposure cannot be corrected. Even low levels of lead in blood have been shown to affect IQ, ability to pay attention, and academic achievement. The highest loss of intelligence quotient, an average of 7.3, occurs below 10 micrograms of lead per deciliter of blood. In May 2012, the Center for Disease Control stated that no safe blood lead level in children has been identified, and there no blood lead level that can be used to define individuals in need of intervention. Research in 2008 shows compelling evidence linking childhood lead poisoning to criminal activity later in life.