

**NEIGHBORHOOD COOPERATIVE NURSERY SCHOOL  
21 CHURCH STREET, WINCHESTER, MA. 01890**



THE COMMONWEALTH OF MASSACHUSETTS

Executive Office of Health and Human Services

*Office of Child Care Services*

Dear Physician: \_\_\_\_\_ is enrolled in an early childhood program which is licensed by the Office of Child Care Services. The Office of Child Care Services regulations require the Medical History and Immunization Form to be completed and signed by the child's physician or source of health care. A prompt response is appreciated.

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

IDENTIFICATION

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

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 screened 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 day care provider? If so, please detail below:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Physician's Signature: \_\_\_\_\_

Date: \_\_\_\_\_ Comments: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_