Physician's Report

Discovery World Early Education Center
550 Deep Valley Drive, Suite 217
Rolling Hills Estates, CA 90274
Phone: (310) 265-6650
Fax: (310) 697-3025

CHILD'S INFORMATION

First Name _____ Last Name _____ Date of Birth _____

STATEMENT TO PHYSICIAN

I/We, the undersigned parent(s)/guardian(s) of the above reference child, am/are considering enrollment of my/our child at Discovery World. My/Our child would likely attend _____ am to _____ pm, _____ days/week yet possibly up to the maximum hours of operation of 7:00am to 6:00pm, 5 days/week. Activities include vigorous outdoor play. Please provide a report on my child's health, using the form below. I am / We are submitting this report to my/our child's doctor and hereby authorize release of the medical information contained in this report to Discovery World by e-sign, email, or fax.

Parent / Guardian Name _____ Parent / Guardian Signature _____ Date of Signature _____

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PHYSICIAN'S REPORT

Significant past illnesses, including injuries, diseases, hospitalizations, complications: ☐ Yes ☐ No
Current communicable diseases: ☐ Yes ☐ No
Conditions requiring special attention by Discovery World: ☐ Yes ☐ No
Medications prescribed or specific instructions to be followed by the center: ☐ Yes ☐ No
Known allergies, including medication, insect, food, asthma: ☐ Yes ☐ No
Restrictions to physical exertion or activities: ☐ Yes ☐ No
Evaluation of: Development: _____ Behavior: _____ Language / Speech: _____
Vision: _____ Hearing: _____ Dental: _____ Blood|Urine|X-Ray|EKG|Other: _____

_____
If "Yes" or not typical to any of the above, please provide details.

Screening of Tuberculosis Risk Factors

Risk Factors

- Being born outside of the United States in high prevalence region, including:
  - Asia, Africa, Central America, South America
- Being in an out-of-home placement
- Living with an adult who has been incarcerated in the last 5 years
- Living amongst or being exposed to individuals experiencing homelessness, migrant workers, and/or nursing home residents
- Having abnormal chest X-ray
- Having clinical evidence of TB or suspected of having HIV
- Having a family member with a history of TB or HIV seropositivity

☐ Risk Factors Not Present
OR
☐ Risk Factors Present
If present, the date of mantoux TB skin test was _____, and the results were:
☐ Negative; TB Not Present
OR
☐ Positive; TB Present

Immunization History

Vaccine	1st Dose Date	2nd Dose Date	3rd Dose Date	4th Dose Date	5th Dose Date
DTap | Tdap	2 months	4 months	6 months	18 months	School-Age
Polio (IPV)	2 months	4 months	15 months	School-Age	
Hepatitis B	2 months	4 months	18 months		
HIB Meningitis	2 months	4 months	12 months		
Varicella	15 months	School-Age			
MMR	12 months	School-Age			

Medical Board of CA License # _____ Physician's Phone Number _____ Physician's Address & Zip Code _____

Physician's Name _____ Physician's Signature _____ Date of Signature _____

  Parent/Guardian Initials: _____ _____