West Virginia Department of Health and Human Resources

CHILD HEALTH ASSESSMENT

Child's Name _____ Parent/Guardian _____

DOB ____/____/_____ Home Phone _____ Address _____

Child Care Facility/School _____ _____

Child Care Facility/School Phone _____ Work Phone _____

Note: A copy of the Health Check exam report attached to a copy of the child's immunization record may be substituted for this form.

Health history and medical information pertinent to routine child care and emergencies:

Date Of Exam ____/____/_____

Allergies to food or medicine:

Length/Height	**Weight**	**Head Circumference**	**Blood Pressure**
_____in/cm %ile _____	_____in/cm %ile _____	_____in/cm %ile _____	_____in/cm %ile _____

Physical Examination	**Normal**	**Abnormal/Comments**
Head/Ears/Eyes/Nose/Throat		
Teeth		
Cardiorespiratory		
Abdomen/GI		
Genitalia/Breasts		
Extremeties/Joints/Back/Chest		
Skin/Lymph Nodes		
Neurologic/Tone		
Developmental (e.g. ddst)		

Immunizations	Birth to 1 Month	2 Month	4 Month	6 Month	12-18 Month	4-6 Yrs
DTP/DTaP						
Polio						
HIB						
HEP B						
MMR						
Varicella						
Other (PCV7)						

Note: Ages and number of boosters may vary when immunizations start at older ages.

Screening Tests (If completed)	**Date**	**Normal**	**Abnormal/Comments**
Lead			
Anemia (HGB/HCT)			
Urinalysis (UA)			
Tuberculosis (TB)			
Hearing			
Vision			

Date of Last Dentist's Exam

Note: Age appropriate health services and immunizations must follow the schedule recommended by AAP

Health Problems or Special Needs	**Recommended Treatment/Medications/Special Care** (Attach additional sheets if necessary)

Medical Care Provider

Address

Phone

MD
DO
PA
CRNP

Date **Signature of Physician or CRNP**

ECE-CC-3
12/04