Form I—Child health exam record

PARENTS complete this page.

Child's name	Child's birthdate	Name of provider Telephone #

Parent 1 name	Parent 2 name

Child home address #1	Telephone # 1
Child home address #2	Telephone #2

Where parent # 1 works	Work address	Home phone # Work # Pager # Cellular # Home email Work email
Where parent # 2 works	Work address	Home phone # Work # Pager # Cellular # Home email Work email

In the event of an emergency, the child care provider is authorized to obtain EMERGENCY MEDICAL or DENTAL CARE even if the provider is unable to immediately make contact with the parents/guardian. During an emergency the child care provider is authorized to contact the following person when parent or guardian cannot be reached.

Parent/Guardian Signature: ______________________________ Date __________

Alternate emergency
contact person's name: __________________ Relationship to child: __________ Phone number: __________

Child's doctor's name	Doctor telephone # 1	Hospital choice
Doctor's address	After hours telephone #	Does your child have health insurance? Yes, Company ____________ ID #
Child's dentist's name	Dentist Telephone # 1	Does your child have dental insurance? Yes, Company ____________ ID#
Dentist's Address	After hours telephone #	☐ NO, we do not have health insurance. ☐ NO, we do not have dental insurance.
Other health care specialist name	Telephone #	Type of specialty

Form I—Child health exam record (continued)

Parent concerns **Parent complete this page**

Tell us about your child's health. Place an ✔ in the box ❑ if the sentence applies to your child. Check all that apply to your child.

Growth
❑ I am concerned about my child's growth.

Appetite
❑ I am concerned about my child's eating/feeding habits or appetite.

Rest
❑ I am concerned about the amount of sleep my child needs.

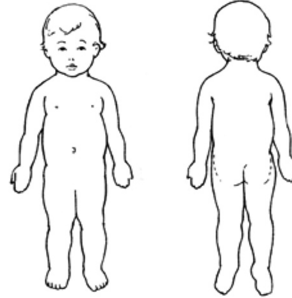
Illness/Surgery/Injury – My child
❑ has had a serious illness, surgery, or injury. *Please describe.*

Physical Activity – My child
❑ must restrict physical activity. *Please describe.*

Medication – My child
❑ takes medication. List meds taken at home, preschool, or in child care. List the name, time medication taken, and the reason medication prescribed.

Development and Learning
❑ I am concerned about my child's behavior, development, or learning. *Please describe.*

Body Health – My child has problems with
❑ Skin, birthmarks, Mongolian spots, hair, finger-nails or toenails.
Map and describe any skin markings



❑ Eyes/vision, glasses
❑ Ears/hearing, hearing aides or device, earaches, tubes in ears
❑ Nose problems, nosebleeds, runny nose
❑ Mouth, teething, gums, tongue, sores in mouth or on lips, mouth-breathing, snoring
❑ Frequent sore throats or tonsillitis
❑ Breathing problems, asthma, cough, croup
❑ Heart, heart murmur
❑ Stomach aches, upset stomach, colic, spitting up
❑ Using toilet, toilet training, urinating
❑ Hard stools, constipation, diarrhea, runny stools
❑ Bones, muscles, movement, pain with moving
❑ Mobility, uses assistive equipment
❑ Nervous system, headaches, seizures, or nervous habits (like twitches)
❑ Needs special equipment. *Please describe.*

Allergy – My child
❑ has allergies (food, medicine, fabric, inhalants, insects, animals, etc.). *Please describe.*

Parent or child care provider questions or concerns to ask health care provider:

Form I—Child health exam record (continued)

Health provider complete this page[1]

Date of exam:

Height or Length:
Weight:
Head Circumference (for children under 2 yr.):
Body Mass Index (for children over 2 yr.):

Blood Pressure (start @ age 3 yr.):
Hgb. or Hct. (start @ 1 yr.):
Blood Lead Level (start @ 1 yr.):
Urinalysis:

Exam Results (n = normal limits) *otherwise describe*

HEENT:
Teeth:
Heart:
Lungs:
Stomach/abdomen:
Genitalia: Tanner stage:
Extremities, joints, muscles, spine:
Skin, lymph nodes:
Neurological:

Sensory and developmental screening

Vision Right eye ________ Left eye _________
Hearing Right ear ________ Left ear _________
Tympanometry (attach results)

Developmental screening results:

Personal-social
Fine motor-adaptive
Language
Gross motor

Developmental referral made today: ❑ Yes ❑ No

[1] The American Academy of Pediatrics has recommendations for frequency of childhood preventative pediatric health care (RE9939, March 2000) www.aap.org

Birthdate: **Age today:**

Date of last dental exam:
Dental referral made today: ❑ Yes ❑ No

Vaccines given today:

DtaP/DTP/Td
HEP B
HIB
Influenza
MMR
Pneumococcal
Polio
Varicella
Other

TB testing (for high risk child only)

Referrals made today:

Physician authorizes the child may receive the following medications while at child care: (include over-the-counter and prescribed):

Medication name *Dosage*

Diaper creme:

Pain reliever:

Sunscreen:

Cough medication:

Form I—Child health exam record (continued)

Health provider completes this section—Assessment Statement:

The child may participate in developmentally appropriate child care/preschool with **NO** health-related restrictions.
The child may participate in developmentally appropriate child care/preschool **with these restrictions.**
Describe all restrictions:

Health Provider *(may use stamp)*
Print name: ____
Signature ____
Provider's Type *(circle)* MD DO PA ARNP
Health Care Provider Address: _______________________________
Health Care Provider Telephone: _____________________________
Additional Comments from the Health Care Provider:

Health Provider's Guide to Recommendations for Preventive Pediatric Health Care

Health Provider's Guide	**AGE**[2]											
	1 mo	2 mo	4 mo	6 mo	9 mo	12 mo	15 mo	18 mo	24 mo	3 yr	4 yr	5 yr
History: Initial and Interval	●	●	●	●	●	●	●	●	●	●	●	●
Measurement: Height/ Weight	●	●	●	●	●	●	●	●	●	●	●	●
Head Circumference	●	●	●	●	●	●	●	●	●			
Blood Pressure										●	●	●
Sensory Screen: Vision	S	S	S	S	S	S	S	S	S	O	O	O
Hearing	O	S	S	S	S	S	S	S	S	S	O	O
Developmental Screening	●	●	●	●	●	●	●	●	●	●	●	●
Complete Unclothed Physical Exam	●	●	●	●	●	●	●	●	●	●	●	●
Lab: Hereditary/Metabolic Screen	●[3]											
Hematocrit or Hemoglobin					● →	→	♦ →	→	→	→	→	→
Urinalysis												●
Lead Test						●		♦	●[4]	♦	♦	♦
Cholesterol Screen									♦ →	→	→	→
TB test[5]						♦ →	→	→	→	→	→	→
Immunizations:	●	●	●	●	●	●	●	●	●	●	●	●
Family Guidance: Injury Prevention	●	●	●	●	●	●	●	●	●	●	●	●
Child Car Seat Counseling	●	●	●	●	●	●	●	●	●	●	●	●
Tricycle Helmet Counseling									●	●	●	●
Sleep Position Counseling	●	●	●	●	●	●						
Nutrition & Physical Activity Counseling	●	●	●	●	●	●	●	●	●	●	●	●
Violence Prevention	●	●	●	●	●	●	●	●	●	●	●	●
Child Development Guidance	●	●	●	●	●	●	●	●	●	●	●	●

Key: ● = to be performed
♦ = to be performed for at-risk children
→ = Range in which the task may be completed
S = Subjective, by history
O = Objective, by standard testing

[2] If a child comes under care for the first time at any point on the schedule, or if any items are not accomplished at the suggested age, the schedule should be brought up to date at the earliest possible time.
[3] All newborns should receive metabolic screening (e.g. Thyroid, hemoglobinopathies, PKU, galactosemia) during neonatal period.
[4] Lead testing should be done at 12 & 24 months, Testing may be done at additional times for children determined at risk.
[5] TB testing for only at-risk children.