CHILD HEALTH FORM

TO BE COMPLETED BY PARENT OR GUARDIAN:

_____ _____ _____ _____/_____/_____

CHILD'S LAST NAME | FIRST NAME | M.I | DOB: MO DAY YEAR

_____

CHILD'S ADDRESS

WE/I _____ GIVE PERMISSION TO OBTAIN/RELEASE MEDICAL INFORMATION

SIGNATURE OF PARENT/GUARDIAN ON THE ABOVE CHILD.

PLEASE RETURN TO: _____

NAME OF CHILD CARE PROGRAM

HISTORY: TO BE COMPLETED BY PHYSICIAN
(THIS INFORMATION WILL BE HELD CONFIDENTIAL AND WILL BE USED ONLY FOR THE BENEFIT OF THIS CHILD).

A PRENATAL, PERINATAL AND POSTNATAL DEVELOPMENT: ANY SIGNIFICANT FINDINGS THAT COULD INFLUENCE THIS CHILD'S ADAPTATIONS TO A CHILD CARE SETTING (I.E., PHYSICAL HANDICAP, SENSORY LOSS, DEVELOPMENTAL IRREGULARITIES)?

B. ANY CHRONIC ILLNESS THAT MAY REQUIRE MEDICATION, PARTICULARLY OBSERVATIONS OR PRECAUTIONS IN A CHILD CARE SETTING (E.G., RECURRENT EAR INFECTIONS, SEIZURE DISORDER, ALLERGIES)?

C. ANY HOSPITALIZATIONS, OPERATIONS, OR SPECIAL TESTS OF WHICH A CHILD CARE PROVIDER SHOULD BE AWARE?

D. PERTINENT FAMILY, SOCIAL OR HEALTH CHARACTERISTICS?

IMMUNIZATIONS FOR CHILD CARE AGENCY ATTENDANCE
PARENT MAY SUBSTITUTE A COPY OF CHILD'S IMMUNIZATION RECORD

VACCINE	DATE	DATE	DATE	DATE	DATE	DATE
DTP/DTAP						
HIB						
DTP-HIB						
TD						
OPV OR IPV						
MMR						
HEP-B						
VARICELLA						
OTHER						

COMMUNICABLE DISEASE HISTORY

DISEASE	DATE OF DIAGNOSIS	LABORATORY CONFIRMATION	PHYSICIAN
CHICKENPOX		NOT APPLICABLE	
OTHER:			

RECOMMENDED SCREENING & TESTING OF ATTENDEES

	DATE	METHOD	RESULT:
TB (FOR HIGH RISK CHILDREN ONLY)			
VISION			
HEARING			
SPEECH			
HIB/HCT		NOT APPLICABLE	
URINE		NOT APPLICABLE	
LEAD		NOT APPLICABLE	

HEALTH ASSESSMENT: (TO BE COMPLETED BY LICENSED HEALTH PRACTITIONER)

PHYSICAL EXAM:

LENGTH/HEIGHT _____IN/CM %ILE_____	WEIGHT _____LB/KG %ILE_____	HEAD CIRCUMFERENCE _____IN/CM %ILE_____	BLOOD PRESSURE _____/_____

CHECK ( ) EACH LINE	NORMAL	ABNORMAL	NEEDS FOLLOW-UP	NOT EXAMINED	CHECK ( ) EACH LINE	NORMAL	ABNORMAL	NEEDS FOLLOW-UP	NOT EXAMINED
SKIN/SCALP					NOSE, THROAT, MOUTH				
NUTRITION					TEETH & GUMS				
NEUROLOGY & MUSCULAR					GLANDS INC. THYROID				
ORTHOPEDIC & SPINE					CHEST, BREASTS				
EYE					HEART, LUNGS				
EARS					ABDOMEN				
SPEECH					GENITALIA				

TEMPERAMENT: ___ EASY-GOING ___ AVERAGE ___ DIFFICULT

COMMENTS:

ALLERGIES: INCLUDE ALLERGIES TO FOOD, MEDICATION, OR OTHER SUBSTANCES:

ASSESSMENT OF PHYSICAL DEVELOPMENT:

A. ESTIMATE OF LEVEL OF MATURATION:

A. INFANCY (0-2 YEARS)	EARLY: ____	MID: ____	LATE: ____
B. MID-PRESCHOOL (2-4 YEARS)	EARLY: ____	MID: ____	LATE: ____
C. PRESCHOOL (4 YEARS)	EARLY: ____	MID: ____	LATE: ____
D. SCHOOL-AGE (6-10 YEARS)	EARLY: ____	MID: ____	LATE: ____
E. ADOLESCENT (11-18 YEARS)	EARLY: ____	MID: ____	LATE: ____

COMMENTS

B. ESTIMATE OF FUNCTIONAL CAPACITY:

	DELAYED FOR DEVELOPMENT PHASE	CONSISTENT WITH DEVELOPMENT PHASE	ADVANCED FOR DEVELOPMENT PHASE	COMMENTS:
GROSS MOTOR:				
FINE MOTOR:				
LANGUAGE SKILLS:				
SOCIAL SKILLS:				
EMOTIONAL:				

_____ _____

PHYSICIAN'S SIGNATURE: DATE OF EXAM:

_____ _____

PHYSICIAN'S NAME - TYPED OR PRINTED TELEPHONE NUMBER

DATE OF NEXT SCHEDULED EXAM: _____