

**CHILD HEALTH FORM
TO BE COMPLETED BY PARENT OR GUARDIAN:**

CHILD'S LAST NAME _____ CHILD'S FIRST NAME _____ M.I. _____ D.O.B. ____/____/____
MO DAY YEAR

CHILD'S ADDRESS _____

WE/I _____ GIVE PERMISSION TO OBTAIN/RELEASE MEDICAL INFORMATION ON THE
SIGNATURE OF PARENT/GUARDIAN 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

RECOMMENDED SCREENING & TESTING OF ATTENDEES

DISEASE	DATE OF DIAGNOSIS	LABORATORY CONFIRMATION	PHYSICIAN		DATE	METHOD	RESULT:
CHICKENPOX		NOT APPLICABLE		TB (FOR HIGH RISK CHILDREN ONLY)			
OTHER:				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 CIRCUMFRENCE _____ IN/CM %ILE _____	BLOOD PRESSURE _____/_____
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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				
EYES					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 DEVELOPMENTAL 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: _____