**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)?

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

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

1. 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 |  |

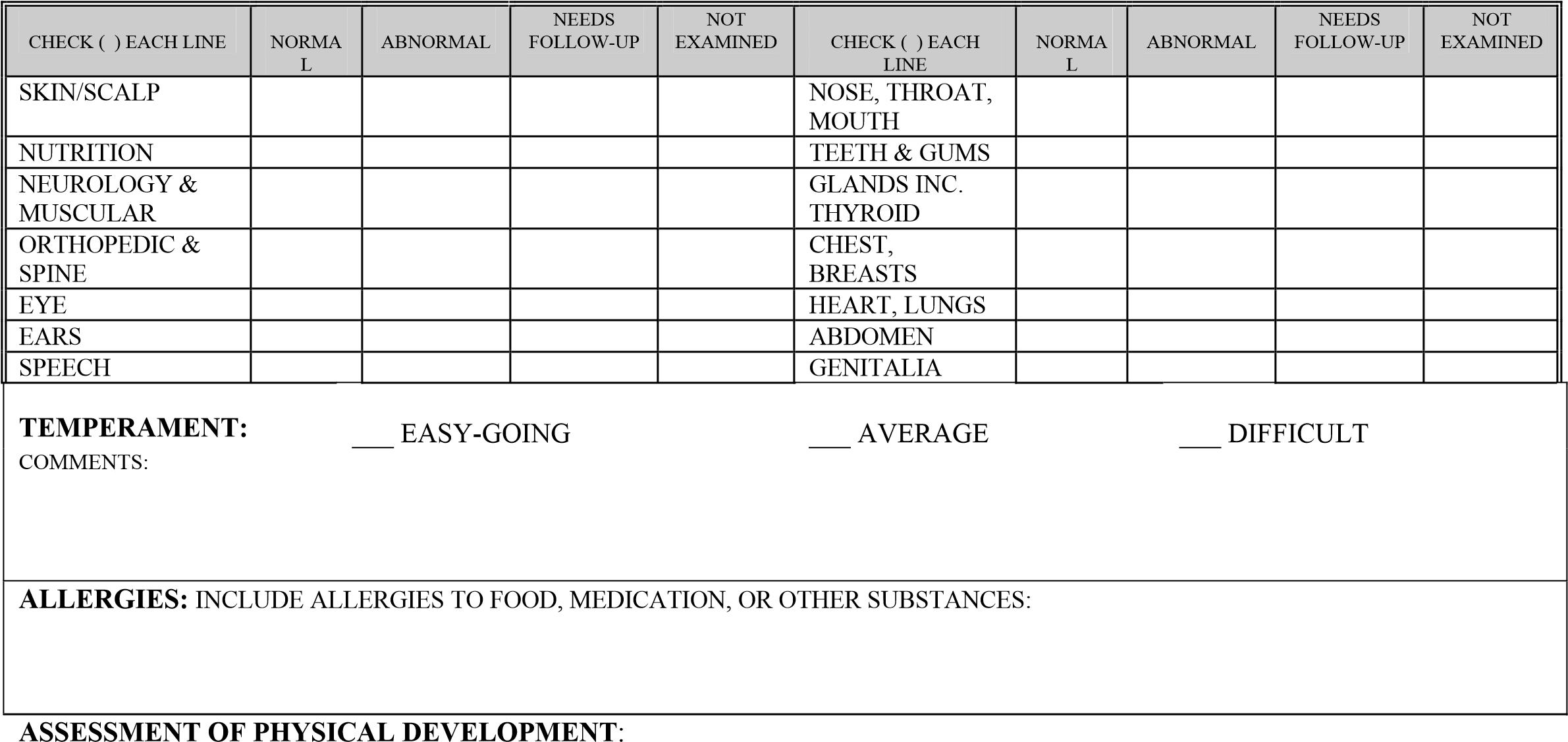
(8)

**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  \_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_ |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **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)  COMMENTS | EARLY: \_\_\_\_ |  | MID: \_\_\_\_ |  |  | LATE: \_\_\_\_ |

**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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_