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