BUTLER COUNTY CHILDREN'S CENTER
Phone: 724-287-2761
Fax: 724-287-4205

Please Complete (If Applicable)

Child's Name: _____

Medication / Food Allergies: _____

Permission to post allergies in classroom: _____
Parent Signature

Lead Test required by Head Start

Test Date: _____ **Test Results** _____

_____ _____
Physician's Name Physician's Signature

CHILD HEALTH ASSESSMENT

CHILD'S NAME: (LAST)	(FIRST)
DATE OF BIRTH:	HOME PHONE:
CHILD CARE FACILITY NAME:	
FACILITY PHONE:	COUNTY:

PARENT/GUARDIAN:
ADDRESS:
WORK PHONE:

PA child care providers must document that enrolled children have received age appropriate health services and immunizations that meet the current schedule of the American Academy of Pediatrics 141 Northwest Point Blvd., Elk Grove Village, IL 60007. The schedule is available at < www.aap.org > or Faxback 847/758-0391 (document #9535 and #9807). Print copies provided by DPW have the schedule on the back of the form.

Health history and medical information pertinent to routine child care and emergencies (describe, if any): ☐ NONE	Date of most recent well-child exam: _____
Allergies to food or medicine (describe, if any): ☐ NONE	Do not omit any information. This form may be updated by health professional. (Initial and date new data.) Child care facility needs 2 copies.

LENGTH/HEIGHT	WEIGHT	HEAD CIRCUMFERENCE	BLOOD PRESSURE
_____IN/CM %ILE_____	_____LB/KG %ILE_____	_____ IN/CM %ILE _____	(BEGINNING AT AGE 3) _____ / _____

PHYSICAL EXAMINATION	☑ =NORMAL	IF ABNORMAL - COMMENTS
HEAD/EARS/EYES/NOSE/THROAT		
TEETH		
CARDIORESPIRATORY		
ABDOMEN/GI		
GENITALIA/BREASTS		
EXTREMITIES/JOINTS/BACK/CHEST		
SKIN/LYMPH NODES		
NEUROLOGIC & DEVELOPMENTAL		

IMMUNIZATIONS	DATE	DATE	DATE	DATE	DATE	COMMENTS
DTaP/DTP/Td						
POLIO						
HIB						
HEP B						
MMR						
VARICELLA						
PNEUMOCOCCAL						
INFLUENZA						
OTHER						

SCREENING TESTS	DATE TEST DONE	NOTE HERE IF RESULTS ARE PENDING OR ABNORMAL
LEAD		
ANEMIA (HGB/HCT)		
URINALYSIS (UA) at age 5)		
HEARING (subjective until age 4)		
VISION (subjective until age 3)		
PROFESSIONAL DENTAL EXAM		

HEALTH PROBLEMS OR SPECIAL NEEDS, RECOMMENDED TREATMENT/MEDICATIONS/SPECIAL CARE (ATTACH ADDITIONAL SHEETS IF NECESSARY)

☐ NONE

NEXT APPOINTMENT - MONTH/YEAR:

MEDICAL CARE PROVIDER:		SIGNATURE OF PHYSICIAN OR CRNP:	
ADDRESS:			
	PHONE:	LICENSE NUMBER:	DATE FORM SIGNED:

Parents may write immunization dates, health professionals should verify and complete all data.