**CHILD HEALTH REPORT – CHILD CARE CENTERS**

**Use of form:** Use of this form is voluntary; however, completion of this form meets the requirements of DCF 202.08(4), DCF 250.04(6)(a)4. and DCF 251.04(6)(a)8. Failure to comply with these rules may result in issuance of a noncompliance statement. Personal information you provide may be used for secondary purposes [Privacy Law, s.15.04(1)(m), Wisconsin Statutes].

**Instructions:** Each child under 2 years of age shall have an initial health examination not more than 6 months prior to nor later than 3 months after being admitted to the center and a follow-up health examination at least once every 6 months thereafter. Each child 2 years of age but who is not 5 years of age or older shall have an initial health examination not more than one year prior to nor later than 3 months after being admitted to a center and a follow-up health examination at least once every 2 years thereafter. The parent / guardian shall give this form to the physician, physician assistant, or other EPSDT provider to be completed, signed, and dated. The licensee / operator shall obtain a copy for the child’s record. Note: Children are also required to have on file at the child care center documentation of immunizations; it may be helpful if the parent / guardian includes a copy of the child’s immunization record when submitting this form to the child care center.

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| **PARENT OR GUARDIAN** – This section should be completed by the parent or guardian | | | | |
| Child’s Name (Last, First, MI) | | | | Child’s Birthdate (mm/dd/yyyy) |
| Child’s Address (Street, City, State, Zip Code) | | | | |
| Parent or Guardian Name (Last, First, MI) | | | | |
| Parent or Guardian Address (Street, City, State, Zip Code) | | | | |
| **HEALTH PROFESSIONAL** – This section should be completed by the health professional | | | | |
| Instructions for feeding and care of child with special health concerns – Specify: (attach information as necessary). | | | |
| Yes  No Does the child have a milk allergy? If “Yes,” identify the recommended milk substitute. | | | |
| Yes  No Does this child have any food or non-food allergies? If “Yes,” specify and include the treatment plan to be implemented in the event of an allergic reaction. | | | |
| Date of child’s most recent blood lead test: |  | (mm/dd/yyyy). | |
| Note: Children on Medicaid are required to be tested at around ages 12 months and 24 months or once between the ages of 3 and 5 years if no previous test is documented. Lead testing is optional for children who are not on Medicaid. | | | |
| Immunization(s) not to be administered to child due to medical reason(s) – Specify. | | | |
| **AUTHORIZATION** | | | |
| I certify that I have examined the above child on this date and that he / she is able to participate in child care activities. | | | |
| Name – MD, PA, or other EPSDT Provider (type or print) | | Address (Street, City, State, Zip Code) | |
| SIGNATURE – MD, PA, or other EPSDT Provider | | | Date of Examination |