CHILD'S FULL NAME _____ DATE OF BIRTH _____

#2: CHILD HEALTH ASSESSMENT/PHYSICAL EXAM FORM

Child's Name (Last):	Child's Name (First):	Child's Date of Birth:
Parent/Guardian Name:	Address:	Contact 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 care and emergencies (describe, if any): ❑ **NONE**	**DATE OF MOST RECENT WELL-CHILD/PHYSICAL 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).

IN YOUR ASSESSMENT, IS THE CHILD ABLE TO PARTICIPATE IN CHILD CARE AND DOES THE CHILD APPEAR TO BE FREE FROM CONTAGIOUS OR COMMUNICABLE DISEASES?

❑ YES

❑ NO - IF NO, PLEASE EXPLAIN YOUR ANSWER:

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

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

IMMUNIZATIONS	DATE	DATE	DATE	DATE	DATE	COMMENTS
DTap/DTP/Td						
POLIO						
HIB						
HEP B						
MMR						
VARICELLA						
MENINGOCOCCAL						
PNEUMOCOCCAL						
INFLUENZA						
HEP A						
ROTAVIRUS						
OTHER/TB						

SCREENING TESTS	DATE OF TEST	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:			
ZIP CODE:	PHONE:	LICENSE NUMBER:	DATE FORM SIGNED: