CHILD HEALTH ASSESSMENT

Parents & Child Care Providers fill-in this part.

CHILD'S NAME: (LAST)	(FIRST)	PARENT/ GUARDIAN:
DATE OF BIRTH	HOME PHONE:	ADDRESS:
CHILD CARE FACILITY NAME:		
FACILITY PHONE:	COUNTY	WORK PHONE:

To Parents: Submission of this form to the child care provider implies consent for the child care provider to discuss the child's health with the child's clinician.

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.

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

LENGTH/ HEIGHT	WEIGHT	HEAD CIRCUMFERENCE (BIRTH to AGE 2)	BLOOD PRESSURE (BEGINNING AT AGE 3)
_____ IN/ CM % ILE _____	_____ LB/ KG % ILE _____	_____ IN/ CM % ILE _____	_____ / _____

PHYSICAL EXAMINATION	✓ = NORMAL	IF ABNORMAL – COMMENTS
HEAD/ EARS/ EYES/ NOSE/ THROAT		
TEETH		
CARDIORESPIRATORY		
ABDOMEM/ 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						
OTHER						

SCREENING TESTS	DATE TEST DONE	NOTE HERE IF RESULTS ARE PENDING OR ABNORMAL
LEAD		
ANEMIA (HGB/ HCT)		
URINANLYSIS (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:

MEDCAL CARE PROVIDER:		SIGNATURE OF PHYSICIAN OR CPNP:	
ADDRESS:			
	PHONE:	LICENSE NUMBER:	DATE FORM SIGNED: