Child Health Assessment

CHILD'S NAME (LAST)	(FIRST)
DATE OF BIRTH	HOME NUMBER
CHILD CARE FACILITY NAME	
DOCTORS NAME	PHONE NUMBER(S)

PARENT/GUARDIAN	PHONE
PARENT/GUARDIAN	PHONE
PLACE OF EMPLOYMENT	PHONE
ADDRESS	EMAIL

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 school.

Child Care providers must document that enrolled children have received age appropriate health services and immunization.

Health history and medical information pertinent to routine child care and emergencies (describe, if any)	**Date of most recent well-child exam:**
Allergies to food or medicine (describe, if any)	

LENGTH/ HEIGHT	WEIGHT	HEAD CIRCUMFERENCE	BLOOD PRESSURE & TYPE
_____'_____Feet/Inches	_____ Lbs	_____Inches	_____ & _____

PHYSICAL EXAMINATION	X = NORMAL	IF ABNORMAL - COMMENTS
Head/Ears/Eyes/Nose/Throat		
Teeth		
Cardio respiratory		
Abdomen		
Rectal		
Extremities/joints/back/chest		
Hair/Scalp/Skin/Lymp Node		
Neurologic & Developmental		

IMMUNIZATION	DATE	DATE	DATE	DATE	DATE	DATE	COMMENTS
D.P.T Hib							
Hep. B							
Booster							
Polio							
Booster							
MMR							
MMR							
Rubella							

SCREENING TEST	DATE TEST DONE	
Anemia		
Urinalysis		
Hearing		
Vision		
Processional Dental Exam		

Health Problems or Special Needs, Recommended Treatment/Medications/Special Care (Attach Additional Sheets If Necessary)

Signature of Doctor	Stamp of Doctor/Clinic & Date