CHILD HEALTH FORM

To Be Completed by Parent or Guardian:

_____ _____ _____ _____/_____/_____ _____ _____

LAST NAME FIRST NAME M.I. DOB: MO DAY YEAR BOY GIRL

_____

CHILD'S ADDRESS

We/I _____give permission to obtain or release necessary information on the above child.

Please return to: _____

HISTORY: To be Completed by Physician (This information will be held confidential and will be used only for the benefit of this child).

A. Prenatal, perinatal and postnatal development: Any significant findings that could influence this child's adaptations to a child care setting (i.e., physical handicap, sensory loss, developmental irregularities)?

B. Any chronic illness that may require medication, particularly observations or precautions in a child care setting (e.g., recurrent ear infections, seizure disorder, allergies)?

C. Any hospitalizations, operations, or special tests of which a child care provider should be aware?

D. Pertinent family, social or health characteristics?

IMMUNIZATIONS FOR CHILD CARE AGENCY ATTENDANCE

You May Substitute A Copy Of Your Own Immunization Record

Vaccine	Date	Date	Date	Date	Date	Date
DTP/DTaP						
Hib						
DTP-Hib						
Td						
OPV or IPV						
MMR						
Hep-B						
Varicella						
Other						

Communicable Disease History **Recommended Screening & Testing of Attendees**

Disease	Date of Diagnosis	Laboratory Confirmation	Physician		Date	Method	Result:
Chickenpox		Not Applicable		TB (For High Risk Children Only)			
Other:				Vision			
				Hearing			
				Speech			
				HIB/HCT		Not Applicable	
				Urine		Not Applicable	
				Lead		Not Applicable	

HEALTH ASSESSMENT

PHYSICAL EXAM:

LENGTH/HEIGHT ____IN/CM %ILE____	WEIGHT ____LB/KG %ILE____	HEAD CIRCUMFERENCE ____IN/CM %ILE____	BLOOD PRESSURE _____/_____

Check ( ) Each Line	Normal	Abnormal	Needs Follow-up	Not Examined	Check ( ) Each Line	Normal	Abnormal	Needs Follow-up	Not Examined
Skin/Scalp					Nose, Throat, Mouth				
Nutrition					Teeth & Gums				
Neurology & Muscular					Glands inc. Thyroid				
Orthopedic & Spine					Chest, Breasts				
Eye					Heart, Lungs				
Ears					Abdomen				
Speech					Genitalia				

Temperament: ____Easy-going ____Average ____Difficult

Comments:

Assessment of Physical Development:

A. Estimate of level of maturation:

a.	**Infancy (0-2 years)**	**Early:____**	**Mid:____**	**Late:____**
b.	**Mid-Preschool (2-4 years)**	**Early:____**	**Mid:____**	**Late:____**
c.	**Preschool (4 years)**	**Early:____**	**Mid:____**	**Late:____**
d.	**School age (6-10 years)**	**Early:____**	**Mid:____**	**Late:____**
e.	**Adolescent (11-18 years)**	**Early:____**	**Mid:____**	**Late:____**

B. Estimate of functional capacity:

	Delayed for Development Phase	Consistent with Development Phase	Advanced for Development Phase	Comments:
Gross Motor:				
Fine Motor:				
Language Skills:				
Social Skills:				
Emotional:				

Physican's Signature:_____ Date of Exam: _____

Date of Next Scheduled Exam: _____