

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): <input type="checkbox"/> NONE	Date of most recent well-child exam: _____
Allergies to food or medicine (describe, if any): <input type="checkbox"/> 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		BLOOD PRESSURE	
IN/CM % ILE		LB/KG % ILE		IN/CM % ILE		(BEGINNING AT AGE 3) /	
PHYSICAL EXAMINATION		✓ = NORMAL		IF ABNORMAL - COMMENTS			
HEAD/EARS/EYES/NOSE/THROAT							
TEETH							
CARDIORESPIRATORY							
ABDOMEN/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)							
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)	
<input type="checkbox"/> NONE				NEXT APPOINTMENT - MONTH/YEAR:			
MEDICAL CARE PROVIDER: SIGNATURE OF PHYSICIAN OR CPNP:				SIGNATURE OF PHYSICIAN OR CPNP:			
ADDRESS:							
			PHONE	LICENSE NUMBER:	DATE FORM SIGNED:		

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