

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 Little Bear Day Care		
FACILITY PHONE: 304-379-2327	COUNTY: Preston	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.nap.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)
PHYSICAL EXAMINATION <input checked="" type="checkbox"/> = 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
DTaP/DTP/Td			
POLIO			
HIB			
HEP B			
MHR			
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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