

CHILD HEALTH ASSESSMENT

CHILD'S NAME: (LAST)	(FIRST)
DATE OF BIRTH:	HOME PHONE:
CHILD CARE FACILITY NAME:	
FACILITY PHONE:	COUNTY:

PARENT/GUARDIAN:
ADDRESS:
WORK PHONE:

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.

Parents & Child Care Providers fill-in this part.

Health history and medical information pertinent to routine child care and emergencies (describe, if any): <input type="checkbox"/> NONE <input type="checkbox"/> ALLERGIES TO FOOD OR MEDICINE (describe, if any): <input type="checkbox"/> NONE	Date of most recent well-child exam: Do not omit any information. This form may be updated by health professional. (Initial and date new data.) Child care facility needs 2 copies.
--	--

LENGTH/HEIGHT	WEIGHT	HEAD CIRCUMFERENCE	BLOOD PRESSURE	PHYSICAL EXAMINATION	
IN/CM %ILE _____	LB/KG %ILE _____	IN/CM %ILE _____	(BEGINNING AT AGE 3) _____ / _____	<input checked="" type="checkbox"/> NORMAL	
				<input type="checkbox"/> 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	COMMENTS
DTaP/DTP/d					
POLIO					
HIB					
HEP B					
MMR					
VARICELLA					
PNEUMOCOCCAL					
INFLUENZA					
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 MEDICAL CARE PROVIDER:		NEXT APPOINTMENT - MONTH/YEAR:	
ADDRESS:		SIGNATURE OF PHYSICIAN OR CRNP:	
PHONE:	LICENSE NUMBER:	DATE FORM SIGNED:	

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