

CHILD HEALTH ASSESSMENT



CHILD'S NAME: (LAST)	(FIRST)	PARENT/GUARDIAN:
DATE OF BIRTH:	CHILD CARE FACILITY NAME:	ADDRESS:

DO NOT OMIT ANY INFORMATION

Health history and medical information pertinent to routine child care and emergencies (describe, if any):

NONE

Describe all medication and any special diet the child receives and the reason for medication and special diet. All medications a child receives should be documented in the event the child requires emergency medical care. Attach additional sheets if necessary.

NONE

Allergies to food or medicine (describe, if any):

NONE

List any health problems or special needs and recommended treatment/services. Attach additional sheets as needed to describe the plan for care that should be followed, including indication of special training required for staff, equipment, and provision for emergencies.

NONE

In your assessment, is the child able to participate in child care, and does the child appear to be free from contagious or communicable diseases?

Yes No If no, please explain:

LENGTH/HEIGHT	WEIGHT	HEAD CIRCUMFERENCE	BLOOD PRESSURE
IN/CM % ILE	LB/K % ILE	(BIRTH TO AGE 2) IN/CM % LE	(BEGINNING AT AGE 3) /
PHYSICAL EXAM	✓=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: RECORD DATES BELOW OR ATTACH A PHOTOCOPY OF THE CHILD'S IMMUNIZATION RECORD.

	DATE	DATE	DATE	DATE	DATE	COMMENTS
POLIO						
DTAP						
MMR						
HIB						
HEP B						
VARICELLA						
HEP A						
PNEUMOCOCCAL						
MENINGOCOCCAL						
OTHER						

SCREENING TESTS	DATE TEST DONE/RESULT	NOTE HERE IF RESULTS ARE PENDING OR ABNORMAL
LEAD		
ANEMIA (HGB/HCT)		
HEARING (subjective until age 4)		
VISION (subjective until age 3)		

HAS THE CHILD RECEIVED ALL AGE-APPROPRIATE SCREENINGS LISTED IN THE ROUTINE PREVENTIVE HEALTH CARE SERVICES CURRENTLY RECOMMENDED BY THE AMERICAN ACADEMY OF PEDIATRICS? Yes No If no, please explain:

MEDICAL CARE PROVIDER:	SIGNATURE OF PHYSICIAN OR CRNP:		
ADDRESS:			
PHONE:	LICENSE NUMBER:	DATE:	