# CHILD HEALTH ASSESSMENT

SUMMIT EARLY LEARNING

| CHILD'S NAME: (LAST) | (FIRST) |
|---|---|
| DATE OF BIRTH: | CHILD CARE FACILITY NAME: |

| PARENT/GUARDIAN: |
|---|
| ADDRESS: |

**HEALTH PROVIDER COMPLETES THIS SECTION**

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:

**HAS THE CHILD RECEIVED ALL AGE-APPROPRIATE SCREENINGS LISTED IN THE ROUITINE PREVENTIVE HEALTH CARE SERVICES CURRENTLY RECOMMENDED BY THE AMERICAN ACADEMY OF PEDIATRICS?** ☐ 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 % ILE_____ | (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 COPY OF THE CHILD'S IMMUNIZATION RECORD.**

| | DATE | DATE | DATE | DATE | DATE | COMMENTS |
|---|---|---|---|---|---|---|
| POLIO | | | | | | |
| DTAP | | | | | | |
| MMR | | | | | | |
| HIB | | | | | | |
| HEP B | | | | | | |
| VARICELLA | | | | | | |
| HEP A | | | | | | |
| PNEUMOCOCCAL | | | | | | |
| ROTAVIRUS | | | | | | |
| MENINGOCOCCAL | | | | | | |
| FLU/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) | | |

| MEDICAL CARE PROVIDER: | | SIGNATURE OF PHYSICIAN, P.A. OR CRNP: | |
|---|---|---|---|
| Address: | | | Date form completed: |
| | Phone: | License number: | Date of well child exam: |