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: