

**CHILD HEALTH FORM  
TO BE COMPLETED BY PARENT OR GUARDIAN:**

CHILD'S LAST NAME \_\_\_\_\_ FIRST NAME \_\_\_\_\_ M.I \_\_\_\_\_ DOB: MO \_\_\_\_ / DAY \_\_\_\_ / YEAR \_\_\_\_

CHILD'S ADDRESS \_\_\_\_\_  
WE/I \_\_\_\_\_ GIVE PERMISSION TO OBTAIN/RELEASE MEDICAL INFORMATION  
SIGNATURE OF PARENT/GUARDIAN ON THE ABOVE CHILD.

PLEASE RETURN TO: \_\_\_\_\_  
NAME OF CHILD CARE PROGRAM

**HISTORY: TO BE COMPLETED BY PHYSICIAN  
(THIS INFORMATION WILL BE HELD CONFIDENTIAL AND WILL BE USED ONLY FOR THE BENEFIT OF THIS CHILD).**

A. PRENATAL, PERINATAL AND POSTNATAL DEVELOPMENT: ANY SIGNIFICANT FINDINGS THAT COULD INFLUENCE THIS CHILD'S ADAPTATIONS TO A CHILD CARE SETTING (I.E., PHYSICAL HANDICAP, SENSORY LOSS, DEVELOPMENTAL IRREGULARITIES)?

B. ANY CHRONIC ILLNESS THAT MAY REQUIRE MEDICATION, PARTICULARLY OBSERVATIONS OR PRECAUTIONS IN A CHILD CARE SETTING (E.G., RECURRENT EAR INFECTIONS, SEIZURE DISORDER, ALLERGIES)?

C. ANY HOSPITALIZATIONS, OPERATIONS, OR SPECIAL TESTS OF WHICH A CHILD CARE PROVIDER SHOULD BE AWARE?

D. PERTINENT FAMILY, SOCIAL OR HEALTH CHARACTERISTICS?

**IMMUNIZATIONS FOR CHILD CARE AGENCY ATTENDANCE  
PARENT MAY SUBSTITUTE A COPY OF CHILD'S IMMUNIZATION RECORD**

VACCINE	DATE	DATE	DATE	DATE	DATE	DATE
DTP/DTAP						
HIB						
DTP-HIB						
TD						
OPV OR IPV						
MMR						
HEP-B						
VARICELLA						
OTHER						

**COMMUNICABLE DISEASE HISTORY**

**RECOMMENDED SCREENING & TESTING OF ATTENDEES**

DISEASE	DATE OF DIAGNOSIS	LABORATORY CONFIRMATION	PHYSICIAN		DATE	METHOD	RESULT:
CHICKENPOX		NOT APPLICABLE		TB (FOR HIGH RISK CHILDREN ONLY)			
OTHER:				VISION			
				HEARING			
				SPEECH			
				HIB/HCT		NOT APPLICABLE	
				URINE		NOT APPLICABLE	
				LEAD		NOT APPLICABLE	

**HEALTH ASSESSMENT: (TO BE COMPLETED BY LICENSED HEALTH PRACTITIONER)**

**PHYSICAL EXAM:**

LENGTH/HEIGHT _____ IN/CM    %ILE _____	WEIGHT _____ LB/KG    %ILE _____	HEAD CIRCUMFERENCE _____ IN/CM    %ILE _____	BLOOD PRESSURE _____ / _____
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CHECK ( ) EACH LINE	NORMA L	ABNORMAL	NEEDS FOLLOW-UP	NOT EXAMINED	CHECK ( ) EACH LINE	NORMA L	ABNORMAL	NEEDS FOLLOW-UP	NOT EXAMINED
SKIN/SCALP					NOSE, THROAT, MOUTH				
NUTRITION					TEETH & GUMS				
NEUROLOGY & MUSCULAR					GLANDS INC. THYROID				
ORTHOPEDIC & SPINE					CHEST, BREASTS				
EYE					HEART, LUNGS				
EARS					ABDOMEN				
SPEECH					GENITALIA				

**TEMPERAMENT:**                \_\_\_ EASY-GOING                                \_\_\_ AVERAGE                                \_\_\_ DIFFICULT

COMMENTS:

**ALLERGIES:** INCLUDE ALLERGIES TO FOOD, MEDICATION, OR OTHER SUBSTANCES:

**ASSESSMENT OF PHYSICAL DEVELOPMENT:**

**A. ESTIMATE OF LEVEL OF MATURATION:**

- |                              |              |            |             |
|------------------------------|--------------|------------|-------------|
| A. INFANCY (0-2 YEARS)       | EARLY: _____ | MID: _____ | LATE: _____ |
| B. MID-PRESCHOOL (2-4 YEARS) | EARLY: _____ | MID: _____ | LATE: _____ |
| C. PRESCHOOL (4 YEARS)       | EARLY: _____ | MID: _____ | LATE: _____ |
| D. SCHOOL-AGE (6-10 YEARS)   | EARLY: _____ | MID: _____ | LATE: _____ |
| E. ADOLESCENT (11-18 YEARS)  | EARLY: _____ | MID: _____ | LATE: _____ |

COMMENTS

**B. ESTIMATE OF FUNCTIONAL CAPACITY:**

	DELAYED FOR DEVELOPMENT PHASE	CONSISTENT WITH DEVELOPMENT PHASE	ADVANCED FOR DEVELOPMENT PHASE	COMMENTS:
GROSS MOTOR:				
FINE MOTOR:				
LANGUAGE SKILLS:				
SOCIAL SKILLS:				
EMOTIONAL:				

\_\_\_\_\_  
PHYSICIAN'S SIGNATURE:

\_\_\_\_\_  
DATE OF EXAM:

\_\_\_\_\_  
PHYSICIAN'S NAME - TYPED OR PRINTED

\_\_\_\_\_  
TELEPHONE NUMBER

DATE OF NEXT SCHEDULED EXAM: \_\_\_\_\_