

# CHILD HEALTH ASSESSMENT

Parents &amp; Child Care Providers fill-in this part.

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

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](http://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.

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

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

LENGTH/HEIGHT	WEIGHT	HEAD CIRCUMFERENCE	BLOOD PRESSURE
_____ IN/CM %ILE _____	_____ LB/KG %ILE _____	_____ IN/CM %ILE _____	(BEGINNING AT AGE 3) _____ / _____
<b>PHYSICAL EXAMINATION</b>	<input checked="" type="checkbox"/> =NORMAL	<b>IF ABNORMAL - COMMENTS</b>	
HEAD/EARS/EYES/NOSE/THROAT			
TEETH			
CARDIORESPIRATORY			
ABDOMEN/GI			
GENITALIA/BREASTS			
EXTREMITIES/JOINTS/BACK/CHEST			
SKIN/LYMPH NODES			
NEUROLOGIC & DEVELOPMENTAL			
<b>IMMUNIZATIONS</b>	<b>DATE</b>	<b>DATE</b>	<b>DATE</b>
DTaP/DTP/Td			
POLIO			
HIB			
HEP B			
MMR			
VARICELLA			
PNEUMOCOCCAL			
INFLUENZA			
OTHER			
<b>SCREENING TESTS</b>	<b>DATE TEST DONE</b>	<b>NOTE HERE IF RESULTS ARE PENDING OR ABNORMAL</b>	
LEAD			
ANEMIA (HGB/HCT)			
URINALYSIS (UA) at age 5)			
HEARING (subjective until age 4)			
VISION (subjective until age 3)			
PROFESSIONAL DENTAL EXAM			
<b>HEALTH PROBLEMS OR SPECIAL NEEDS, RECOMMENDED TREATMENT/MEDICATIONS/SPECIAL CARE</b> (ATTACH ADDITIONAL SHEETS IF NECESSARY)			
<input type="checkbox"/> NONE			
<b>MEDICAL CARE PROVIDER:</b>		<b>NEXT APPOINTMENT - MONTH/YEAR:</b>	
ADDRESS:		SIGNATURE OF PHYSICIAN OR CRNP:	
	PHONE:	LICENSE NUMBER:	DATE FORM SIGNED: