

CHILD HEALTH ASSESSMENT

Parents & Child Care Providers fill-in this part.

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

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 > 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 professionals 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) _____ / _____			
PHYSICAL EXAMINATION	<input checked="" type="checkbox"/> =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	DATE	DATE	DATE	DATE	DATE	COMMENTS
DTaP/DTP/Td						
POLIO						
HIB						
HEP B						
MMR						
VARICELLA						
PNEUMOCOCCAL						
INFLUENZA						
OTHER						
SCREENING TESTS	DATE TEST DONE	NOTE HERE IF RESULTS ARE PENDING OR ABNORMAL				
LEAD						
ANEMIA (HGB/HCT)						
URINALYSIS (UA) at age 5)						
HEARING (subjective until age 4)						
VISION (subjective until age 3)						
PROFESSIONAL DENTAL EXAM						

HEALTH PROBLEMS OR SPECIAL NEEDS, RECOMMENDED TREATMENT/MEDICATIONS/SPECIAL CARE (ATTACH ADDITIONAL SHEETS IF NECESSARY)

NONE

MEDICAL CARE PROVIDER:	NEXT APPOINTMENT - MONTH/YEAR:
ADDRESS:	SIGNATURE OF PHYSICIAN OR CRNP:
PHONE:	LICENSE NUMBER:
	DATE FORM SIGNED: