CHILD HEALTH ASSESSMENT

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

I give my consent for my child's Physician and Child Care Provider to discuss my child's health concerns. _____ SIGNATURE _____ DATE

HEALTH HISTORY AND MEDICAL INFORMATION PERTINENT TO ROUTINE CHILD CARE AND EMERGENCIES: ☐ NONE

DATE OF EXAM _____

ALLERGIES TO FOOD OR MEDICINE: ☐ NONE

LENGTH/HEIGHT	WEIGHT	HEAD CIRCUMFERENCE	BLOOD PRESSURE
_____IN/CM %ILE _____	_____LB/KG %ILE _____	_____IN/CM %ILE _____	_____ / _____

PHYSICAL EXAMINATION	NORMAL	ABNORMAL/COMMENTS
HEAD/EARS/EYES/NOSE/THROAT		
TEETH		
CARDIORESPIRATORY		
ABDOMEN/GI		
GENITALIA/BREASTS		
EXTREMITIES/JOINTS/BACK/CHEST		
SKIN/LYMPH NODES		
NEUROLOGIC/TONE		
DEVELOPMENTAL (E.G. DDST)		

IMMUNIZATIONS	DATE	DATE	DATE	DATE	DATE	COMMENTS
DTP/DTaP	1	2	3	4	5	
POLIO	1	2	3	4		
HIB	1	2	3	4		
HEP B	1	2	3			
MMR	1	2				
VARICELLA	1	2				
OTHER			NOTE: Ages and number of boosters may vary when immunizations start at older ages.			

SCREENING TESTS	NORMAL	ABNORMAL/COMMENTS
LEAD		
ANEMIA (HGB/HCT)		
URINALYSIS (UA)		
HEARING		
VISION		

DATE OF LAST DENTIST'S EXAMINATION _____

NOTE: Age appropriate health services and immunizations must follow the schedule recommended by The American Academy of Pediatrics, 141 Northwest Point Blvd., Elk Grove Village, IL 60007

HEALTH PROBLEMS OR SPECIAL NEEDS

☐ NO PROBLEMS

RECOMMENDED TREATMENT/MEDICATIONS/SPECIAL CARE (ATTACH ADDITIONAL SHEETS IF NECESSARY)

MEDICAL CARE PROVIDER:

ADDRESS:

PHONE:

NEXT APPOINTMENT: (MONTH/YEAR)

_____ DATE _____ SIGNATURE OF PHYSICIAN OR CRNP

MD
DO
CRNP

04131A

CY 51 - 2/97