

# 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
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<b>HEALTH PROBLEMS OR SPECIAL NEEDS</b>  <input type="checkbox"/> NO PROBLEMS	<b>RECOMMENDED TREATMENT/MEDICATIONS/SPECIAL CARE</b> (ATTACH ADDITIONAL SHEETS IF NECESSARY)
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MEDICAL CARE PROVIDER: ADDRESS: PHONE:	NEXT APPOINTMENT: (MONTH/YEAR):  <div style="text-align: right;">           _____ DATE _____ SIGNATURE OF PHYSICIAN OR CRNP           <div style="float: right; text-align: left; font-weight: bold; font-size: small;">             MD DO CRNP           </div> </div>
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