CHILD HEALTH ASSESSMENT

CHILD'S NAME: (LAST)	(FIRST)
DATE OF BIRTH:	HOME PHONE:
CHILD CARE FACILITY NAME:	
FACILITY PHONE:	COUNTY:

PARENT/GUARDIAN:
ADDRESS:
WORK PHONE:

To Parents: Submission of this form to the child care provider implies consent for the child care provider to discuss the child's health with the child's clinician.

PA child care 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 Fax back 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):

☐ **NONE**

Allergies to food or medicine (describe, if any):

☐ **NONE**

Date of <u>most recent</u> well-child exam:

_____

Do not omit any information. This form may be updated by health professional. (Initial and date new data.) Child care facility needs 2 copies.

LENGTH/HEIGHT	WEIGHT	HEAD CIRCUMFERENCE	BLOOD PRESSURE
_____ IN/CM % ILE _____	_____ LB/KG % ILE _____	(BIRTH TO AGE 2) _____ IN/CM % ILE _____	(BEGINNING AT AGE 3) _____/_____

NUMERICAL LEAD LEVEL: _____ DATE: _____
(Past or Present)

ANEMIA (HGB/HCT) LEVEL: _____ DATE: _____
(Past or Present)

PHYSICAL EXAMINATION	✓ = 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						
OTHER						

SCREENING TESTS	DATE TEST DONE	***Results/Values/Values***
URINALYSIS (UA) (at age 5)		
HEARING (subjective until age 4)		
VISION (subjective until age 3)		
FLUORIDE VARNISH APPLIED?	☐ YES ☐ NO	
PROFESSIONAL DENTAL EXAM		

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

☐ **NONE**

NEXT APPOINTMENT - MONTH/YEAR:

MEDICAL CARE PROVIDER:		SIGNATURE OF PHYSICIAN OR CPNP:	
ADDRESS:			
	PHONE:	LICENSE NUMBER:	DATE FORM SIGNED:

Head Start / Early Head Start of the Lehigh Valley / Pre-K Counts
1520 Hanover Avenue, Allentown, PA 18109
FAX: 610-820-6841 – Attn: Health Services
Email: healthdocuments@cscinc.org