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:

In lieu of completing this form, parent/guardian and primary healthcare provider may attach a copy of current physical exam and immunizations.

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.
Child care providers should 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>.

Health history and medical information pertinent to routine child care and emergencies (describe, if any): ☐ **NONE**	Date of most recent well-child exam:
Allergies to food or medicine (describe, if any): ☐ **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.

ATTACH CARE PLAN FOR CHILDREN WITH SPECIAL HEALTH CARE NEEDS (Appendix O) IF NECESSARY

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	✓= NORMAL	IF ABNORMAL - COMMENTS
HEAD/EARS/EYES/THROAT		
TEETH		
CARDIORESPIRATORY		
ABDOMEN/GI		
GENITALIA/BREATS		
EXTREMITIES/JOINTS/BACK/CHEST		
SKIN/LYMPH NODES		
NEUROLOGIC & DEVELOPMENTAL		

Please check that we have your Georgia Certificate of Immunization (Form #3231)

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** **NEXT APPOINTMENT – MONTH/YEAR:**

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

Adapted from the Pennsylvania Department of Public Welfare, 2001, form.