

2: CHILD HEALTH ASSESSMENT/PHYSICAL EXAM FORM

Child's Name (last):		Child's Name (First):		Child's Date of Birth:	
Parent/Guardian Name:		Address:		Contact 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 care and emergencies (describe, if any): <input type="checkbox"/> NONE				DATE OF MOST RECENT WELL-CHILD/PHYSICAL 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).	
LENGTH/HEIGHT		WEIGHT		BLOOD PRESSURE	
IN/CM %1LE		LB/KG %1LE		(BEGINNING AT AGE 3)	
PHYSICAL EXAMINATION		@=NORMAL		IF ABNORMAL- COMMENTS	
HEAD/EYES/EARS/NOSE/THROAT					
TEETH					
CARDIORESPIRATORY					
ABDOMEN/GI					
GENITALIA/BREASTS					
EXTREMITIES/JOINTS/BACK/CHEST					
SKIN/LYMPH NODES					
NEUROLOGIC & DEVELOPMENTAL					
IMMUNIZATIONS	DATE	DATE	DATE	DATE	DATE
DTap/DTP/Td					
POLIO					
HIB					
HEP B					
MMR					
VARICELIA					
MENINGOCOCCAL					
PNEUMOCOCCAL					
INFLUENZA					
HEPA					
ROTAVIRUS					
OTHER/TB					
SCREENING TESTS		DATE OF TEST	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)					
<input type="checkbox"/> NONE					
MEDICAL CARE PROVIDER:			SIGNATURE OF PHYSICIAN OR CRNP:		
ADDRESS:					
ZIP CODE:		PHONE:	LICENSE NUMBER:		DATE FORM SIGNED: