CHILD HEALTH FORM

TO BE COMPLETED BY PARENT OR GUARDIAN:

CHILD'S LAST NAME _____ FIRST NAME _____ M.I _____ DOB: MO ____ / DAY ____ / YEAR ____

CHILD'S ADDRESS _____

WE/I _____ GIVE PERMISSION TO OBTAIN/RELEASE MEDICAL INFORMATION
SIGNATURE OF PARENT/GUARDIAN
ON THE ABOVE CHILD.

PLEASE RETURN TO: Rockwood Acres Childcare, 3 Clough St. Baw 03304
NAME OF CHILD CARE PROGRAM
Fax 228-4460

HISTORY: TO BE COMPLETED BY PHYSICIAN
(THIS INFORMATION WILL BE HELD CONFIDENTIAL AND WILL BE USED ONLY FOR THE BENEFIT OF THIS CHILD).

A PRENATAL, PERINATAL AND POSTNATAL DEVELOPMENT: ANY SIGNIFICANT FINDINGS THAT COULD INFLUENCE THIS CHILD'S ADAPTATIONS TO A CHILD CARE SETTING (I.E., PHYSICAL HANDICAP, SENSORY LOSS, DEVELOPMENTAL IRREGULARITIES)?

B. ANY CHRONIC ILLNESS THAT MAY REQUIRE MEDICATION, PARTICULARLY OBSERVATIONS OR PRECAUTIONS IN A CHILD CARE SETTING (E.G., RECURRENT EAR INFECTIONS, SEIZURE DISORDER, ALLERGIES)?

C. ANY HOSPITALIZATIONS, OPERATIONS, OR SPECIAL TESTS OF WHICH A CHILD CARE PROVIDER SHOULD BE AWARE

D. PERTINENT FAMILY, SOCIAL OR HEALTH CHARACTERISTICS?

IMMUNIZATIONS FOR CHILD CARE AGENCY ATTENDANCE
PARENT MAY SUBSTITUTE A COPY OF CHILD'S IMMUNIZATION RECORD

VACCINE	DATE	DATE	DATE	DATE	DATE	DATE
DTP/DTAP						
HIB						
DTP-HIB						
TD						
OPV OR IPV						
MMR						
HEP-B						
VARICELLA						
OTHER						

COMMUNICABLE DISEASE HISTORY

DISEASE	DATE OF DIAGNOSIS	LABORATORY CONFIRMATION	PHYSICIAN
CHICKENPOX		NOT APPLICABLE	
OTHER:			

RECOMMENDED SCREENING & TESTING OF ATTENDEES

	DATE	METHOD	RESULT
TB (FOR HIGH RISK CHILDREN ONLY)			
VISION			
HEARING			
SPEECH			
HIB/HCT		NOT APPLICABLE	
URINE		NOT APPLICABLE	
LEAD		NOT APPLICABLE	

HEALTH ASSESSMENT: (TO BE COMPLETED BY LICENSED HEALTH PRACTITIONER)

PHYSICAL EXAM:

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

CHECK ( ) EACH LINE	NORMAL	ABNORMAL	NEEDS FOLLOW-UP	NOT EXAMINED	CHECK ( ) EACH LINE	NORMAL	ABNORMAL	NEEDS FOLLOW-UP	NOT EXAMINE
SKIN/SCALP					NOSE, THROAT, MOUTH				
NUTRITION					TEETH & GUMS				
NEUROLOGY & MUSCULAR					GLANDS INC. THYROID				
ORTHOPEDIC & SPINE					CHEST, BREASTS				
EYE					HEART, LUNGS				
EARS					ABDOMEN				
SPEECH					GENITALIA				

TEMPERAMENT: ___ EASY-GOING ___ AVERAGE ___ DIFFICULT

COMMENTS:

ALLERGIES: INCLUDE ALLERGIES TO FOOD, MEDICATION, OR OTHER SUBSTANCES:

ASSESSMENT OF PHYSICAL DEVELOPMENT:

A. ESTIMATE OF LEVEL OF MATURATION:

A. INFANCY (0-2 YEARS)	EARLY: ___	MID: ___	LATE: ___
B. MID-PRESCHOOL (2-4 YEARS)	EARLY: ___	MID: ___	LATE: ___
C. PRESCHOOL (4 YEARS)	EARLY: ___	MID: ___	LATE: ___
D. SCHOOL-AGE (6-10 YEARS)	EARLY: ___	MID: ___	LATE: ___
E. ADOLESCENT (11-18 YEARS)	EARLY: ___	MID: ___	LATE: ___

COMMENTS

B. ESTIMATE OF FUNCTIONAL CAPACITY:

	DELAYED FOR DEVELOPMENT PHASE	CONSISTENT WITH DEVELOPMENT PHASE	ADVANCED FOR DEVELOPMENT PHASE	COMMENTS:
GROSS MOTOR:				
FINE MOTOR:				
LANGUAGE SKILLS:				
SOCIAL SKILLS:				
EMOTIONAL:				

PHYSICIAN'S SIGNATURE: _____ DATE OF EXAM: _____

PHYSICIAN'S NAME - TYPED OR PRINTED _____ TELEPHONE NUMBER _____

DATE OF NEXT SCHEDULED EXAM: _____