CHILD HEALTH REPORT

(55 PA CODE 3270.131, 3280.131 AND 3290.131)

CHILD'S NAME: (LAST) (FIRST)		PARENT/GUARDIAN:
DATE OF BIRTH:	HOME PHONE:	STREET ADDRESS:
CHILD CARE FACILITY NAME: *CHILDREN'S VILLAGE CHILD CARE CENTER*		CITY, STATE, ZIP:
FACILITY PHONE: *(215) 931-0190*	COUNTY: *PHILADELPHIA*	WORK PHONE:

○ I authorize the child care staff and my child's health professional to communicate directly if needed to clarify information on this form about my child.

PARENT'S SIGNATURE:

DO NOT OMIT ANY INFORMATION

HEALTH HISTORY AND MEDICAL INFORMATION PERTINENT TO ROUTINE CHILD CARE AND PIAGNOSIS/TREATMENT IN EMERGENCY (DESCRIBE, IF ANY):

○ NONE

DESCRIBE ALL MEDICATION AND ANY SPECIAL DIET THE CHILD RECEIVES AND THE REASON FOR MEDICATION AND SPECIAL DIET. ALL MEDICATIONS A CHILD RECEIVES SHOULD BE DOCUMENTED IN THE EVENT THE CHILD REQUIRES EMERGENCY MEDICAL CARE. ATTACH ADDITIONAL SHEETS IF NECESSARY.

○ NONE

CHILD'S ALLERGIES (DESCRIBE, IF ANY):

○ NONE

LIST ANY HEALTH PROBLEMS OR SPECIAL NEEDS AND RECOMMENDED TREATMENT/SERVICES. ATTACH ADDITIONAL SHEETS IF NECESSARY TO DESCRIBE THE PLAN FOR CARE THAT SHOULD BE FOLLOWED FOR THE CHILD, INCLUDING INDICATION OF SPECIAL TRAINING REQUIRED FOR STAFF, EQUIPMENT AND PROVISION FOR EMERGENCIES.

○ NONE

IN YOUR ASSESSMENT, IS THE CHILD ABLE TO PARTICIPATE IN CHILD CARE AND DOES THE CHILD APPEAR TO BE FREE FROM CONTAGIOUS OR COMMUNICABLE DISEASES?

○ YES

○ NO IF NO, PLEASE EXPLAIN YOUR ANSWER:

HAS THE CHILD RECEIVED ALL AGE APPROPRIATE SCREENINGS LISTED IN THE ROUTINE PREVENTIVE HEALTH CARE SERVICES CURRENTLY RECOMMENDED BY THE AMERICAN ACADEMY OF PEDIATRICS? (SEE SCHEDULE AT WWW.AAP.ORG)

○ YES

○ NO IF NO, PLEASE EXPLAIN YOUR ANSWER:

NOTE BELOW THE DATE AND RESULT OF SCREENINGS. IF THE SCREENING WAS ABNORMAL, PROVIDE INFORMATION ABOUT REFERRALS, IMPLICATIONS OR ACTIONS RECOMMENDED FOR THE CHILD CARE FACILITY.

VISION (subjective until age 3)	
HEARING (subjective until age 4)	
LEAD	
ANEMIA	

RECORD DATES OF IMMUNIZATIONS BELOW OR ATTACH A PHOTOCOPY OF THE CHILD'S IMMUNIZATION RECORD

IMMUNIZATIONS	DATE	DATE	DATE	DATE	DATE	COMMENTS
HEP - B						
ROTAVIRUS						
DTAP/DTP/TD						
HIB						
PNEUMOCOCCAL						
POLIO						
INFLUENZA						
MMR						
VARICELLA						
HEP-A						
MENINGOCOCCAL						
TB						
OTHER						

PHYSICIAN'S OFFICE AND/OR PARENT: If you wish, you may retain the original form. Copy for the child care provider after initialing and dating new data from each well-child exam.

LAST WELL-CHILD EXAM:					

MEDICAL CARE PROVIDER:		SIGNATURE OF PHYSICAN, CRNP OR PHYSICIAN'S ASSISTANT TITLE:
ADDRESS:		LICENSE NUMBER:
	PHONE:	DATE FORM SIGNED: