

West Virginia Department of Health and Human Resources CHILD HEALTH ASSESSMENT FORM

To be complete by child's physician

Child's full name _____ Parent/Guardian _____
 DOB ___ / ___ / ___ Parent's Phone _____ Address _____
 Child Care Facility/School PIERPONT CHRISTIAN PRESCHOOL _____
 Child Care Facility/School Phone 304-594-3785 Work Phone _____

NOTE: A copy of the Health Check exam report attached to a copy of the child's immunization record may be submitted with this form.

Health history and medical information pertinent to routine child care and emergencies:

Allergies to food or medicine:

Date of exam ___ / ___ / ___

Length/Height in/cm % ile _____	Weight in/cm % ile _____	Head Circumference in/cm % ile _____	Blood Pressure in/cm % ile _____
Physical Examination	Normal	Abnormal/Comments	
Head/Ears/Eyes/Nose/Throat			
Teeth			
Cardio respiratory			
Abdomen/GI			
Genitalia/Breasts			
Extremities/Joints/Back Chest			
Skin/Lymph Nodes			
Neurologic / Tone			
Developmental (e.g. ddst)			

Immunizations	Birth – 1 Month	2 Month	4 Month	6 Month	12 – 18 Month	4 – 6 Yrs
DTP / DtaP						
Polio						
HIB						
HEP B						
MMR						
Varicella						
Other (PCVT)						

Note: Ages and number of boosters may vary when immunizations start at older ages.

Screening Tests (if completed)	Date	Normal	Abnormal / Comments
Lead			
Anemia (HGB/HCT)			
Urinalysis (UA)			
Tuberculosis (TB)			
Hearing			
Vision			

Date of Last Dentist's Exam: ___ / ___ / ___

Note: Age appropriate health services and immunizations must follow the recommended by AAP

Health Problems or Special Needs	Recommended Treatment/Medications/Special Care (Attach additional sheets if necessary)
Medical Care Provider	MD DO PA CRNP
Address	
Phone	Date _____ Signature of Physician or CRNP _____