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

Address

Phone

MD
DO
PA
CRNP

_____

Date **Signature of Physician or CRNP**

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