

CHILD HEALTH APPRAISAL

CHILD DAY CARE CENTERS- GROUP DAY CARE HOMES -FAMILY DAY CARE HOMES

DATE OF EXAM

CHILD'S NAME : LAST, FIRST, MIDDLE	BIRTHDATE
CHILD ADDRESS	TELEPHONE NUMBER

1. REVIEW OF HEALTH HISTORY	2. MEDICAL INFO. PERTINENT TO DIAG. AND TREATMENT IN CASE OF EMERGENCY
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3. SPECIAL INSTRUCTIONS TO PROVIDER REGARDING ANY MEDICATION REQUIRED DURING DAY CARE HOURS	4. RECOMMENDED MODIFICATIONS OR LIMITATIONS OF CHILD'S ACTIVITIES OR DIET (ALLERGIES, ETC.)
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5. VISION (ACUITY) <input type="checkbox"/> NORMAL <input type="checkbox"/> ABNOR-	6. HEARING (AUDITORY) SUBJECTIVE SCREENING DATE _____ AUDITORY DATE _____	7. GROWTH MEASUREMENT Ht. _____' _____ PERCENTILE WT. _____ LBS. _____ PERCENTILE CIRC. _____- _____
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10. DENTAL SCREENING	YES	NO	9. MEDICAL				10. HGB HGB <input type="checkbox"/> NORMAL <input type="checkbox"/> ABNORMAL		
CARIES			EARS/NOSE	NORMAL	ABNOR-	ABDOMEN	NORMAL	ABNOR-	GM OR HTC <input type="checkbox"/> NORMAL <input type="checkbox"/> ABNORMAL
MISSING PERMANENT TEETH			EYES			GENITALIA/ BREASTS			%
ORAL INFECTION			MOUTH/			EXTREMITIES/JOINTS			11. BLOOD PRESSURE /
PROTRUSIONS			LUNGS			SPINE			
			CARDIOVASCULAR			SKIN/ LYMPH			<input type="checkbox"/> NORMAL <input type="checkbox"/> ABNORMAL

12. DEVELOPMENTAL APPRAISAL IS CHILD PROGRESSING NORMALLY WITH AGE OR GROUP? <input type="checkbox"/> YES <input type="checkbox"/> NO	DENVER DEVELOPMENTAL <input type="checkbox"/> YES <input type="checkbox"/> NO
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13. IMMUNIZATIONS					
DTP: DIPHTHERIA-TETANUS-PARESIS	DATE	TRIVALENT ORAL POLIO VACCINE	DATE	OTHER:	DATE
1ST 12 MONTHS		1ST 12 MONTHS		MEASLES (15 MONTHS OR OLDER)	
2ND 14 MONTHS		2ND 14 MONTHS		MUMPS (15 MONTHS OR OLDER)	
3RD 18 MONTHS		3RD 18 MONTHS		RUBELLA (15 MONTHS OR OLDER)	
BOOSTER		4TH (4-8 YEARS)		HIS HOMOPHILES (18 MONTHS)	
BOOSTER		URINALYSIS		TUBERCULOSIS TEST	

14. RECOMMENDED FURTHER MEDICAL TESTS OR EXAMINATION ON THE FOLLOWING:
<input type="checkbox"/> VISION <input type="checkbox"/> GROWTH <input type="checkbox"/> HBG <input type="checkbox"/> HEAD CIRCUMFERENCE <input type="checkbox"/> HEARING <input type="checkbox"/> DENTAL <input type="checkbox"/> BLOOD PRESSURE
<input type="checkbox"/> MEDICAL (SPECIFY)
<input type="checkbox"/> DEVELOPMENTAL PROGRESS (SPECIFY)
<input type="checkbox"/> IMMUNIZATION (SPECIFY)

PRINTED NAME OF PHYSICIAN	TELEPHONE NO.	_____ PHYSICIAN'S SIGNATURE _____ DATE
PHYSICIAN'S ADDRESS		