

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:	ADDRESS:
CHILD CARE FACILITY NAME: CHILD STEPS PRESCHOOL		WORK PHONE:
FACILITY PHONE: 610-789-9970	COUNTY: DELAWARE	

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

THIS FORM MUST BE UPDATED BY A HEALTH PROFESSIONAL. Initial and date any new data. The child care facility needs a copy of the form.

HEALTH HISTORY AND MEDICAL INFORMATION PERTINENT TO ROUTINE CHILD CARE AND DIAGNOSIS/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 PREVENTATIVE HEALTH CARE SERVICES CURRENTLY RECOMMENDED BY THE AMERICAN ACADEMY OF PEDIATRICS? (SEE SCHEDULE AT WWW.AAP.ORG)

YES NO

NOTE BELOW IF THE RESULTS OF VISION, HEARING OR LEAD SCREENINGS WERE ABNORMAL, PROVIDE THE DATE THE SCREENING WAS COMPLETED AND INFORMATION ABOUT REFERRALS, IMPLICATIONS OR ACTIONS RECOMMENDED FOR THE CHILD CARE FACILITY.

VISION (subjective until age 3)

HEARING (subjective until age 4)

LEAD

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						
OTHER						

MEDICAL CARE PROVIDER:

SIGNATURE OF PHYSICIAN, CRNP OR PHYSICIAN ASSISTANT

ADDRESS:

PHONE:

LICENSE NUMBER:

DATE FORM SIGNED: