



# CHILD HEALTH REPORT

(55 PA CODE §§3270.131, 3280.131 AND 3290.131)

Parent/Provider fill in this part.

|                                                                                                                                                                                    |             |                  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------|------------------|
| CHILD'S NAME: (LAST)                                                                                                                                                               | (FIRST)     | PARENT/GUARDIAN: |
| DATE OF BIRTH:                                                                                                                                                                     | HOME PHONE: | ADDRESS:         |
| CHILD CARE FACILITY NAME:                                                                                                                                                          |             |                  |
| FACILITY PHONE:                                                                                                                                                                    | COUNTY:     | WORK PHONE:      |
| <input type="checkbox"/> 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:                                                                                                                                                                |             |                  |

Parents may write immunization dates; health professional should verify and complete all data.

|                                                                                                                                                                                                                                                                                                                                 |      |        |                                                                                                                                                                                                                                                                     |                                                       |      |                   |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------|--------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------|------|-------------------|
| <b>DO NOT OMIT ANY INFORMATION</b><br>This form may 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):<br><input type="checkbox"/> 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.<br><input type="checkbox"/> NONE                           |      |        |                                                                                                                                                                                                                                                                     |                                                       |      |                   |
| CHILD'S ALLERGIES (DESCRIBE, IF ANY):<br><input type="checkbox"/> 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.<br><input type="checkbox"/> 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?<br><input type="checkbox"/> YES <input type="checkbox"/> 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 <a href="http://WWW.AAP.ORG">WWW.AAP.ORG</a> )<br><br><input type="checkbox"/> YES <input type="checkbox"/> NO                        |      |        | <b>NOTE BELOW IF THE RESULTS OF VISION, HEARING OR LEAD SCREENINGS WERE ABNORMAL. IF THE SCREENING WAS ABNORMAL, PROVIDE THE DATE THE SCREENING WAS COMPLETED AND INFORMATION ABOUT REFERRALS, IMPLICATIONS OR ACTIONS RECOMMENDED FOR THE CHILD CARE FACILITY.</b> |                                                       |      |                   |
|                                                                                                                                                                                                                                                                                                                                 |      |        | VISION (subjective until age 3)                                                                                                                                                                                                                                     |                                                       |      |                   |
|                                                                                                                                                                                                                                                                                                                                 |      |        | HEARING (subjective until age 4)                                                                                                                                                                                                                                    |                                                       |      |                   |
|                                                                                                                                                                                                                                                                                                                                 |      |        | LEAD                                                                                                                                                                                                                                                                |                                                       |      |                   |
| <b>RECORD DATES OF IMMUNIZATIONS BELOW OR ATTACH A PHOTOCOPY OF THE CHILD'S IMMUNIZATION RECORD</b>                                                                                                                                                                                                                             |      |        |                                                                                                                                                                                                                                                                     |                                                       |      |                   |
| 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'S ASSISTANT |      |                   |
| ADDRESS:                                                                                                                                                                                                                                                                                                                        |      |        |                                                                                                                                                                                                                                                                     |                                                       |      |                   |
|                                                                                                                                                                                                                                                                                                                                 |      | PHONE: |                                                                                                                                                                                                                                                                     | LICENSE NUMBER:                                       |      | DATE FORM SIGNED: |