**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.*

Date of exam \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

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

Allergies to food or medicine:

|  |  |  |  |
| --- | --- | --- | --- |
| **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 ProviderAddress**Phone** | **MD****DO****PA****CRNP**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date Signature of Physician or CRNP** |

ECE-CC-3 12/04