**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** |

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