

# 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.**

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

Allergies to food or medicine:

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

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 Provider			
Address			
Phone			
		Date	Signature of Physician or CRNP