CHILD HEALTH FORM **(TO BE COMPLETED BY PARENT/GAURDIAN)**

CHILD'S LSAT NAME _______ FIRST NAME _______ M.I. ___ **DOB:** MO / DAY / YEAR

CHILD'S ADDRESS

WE/I _______ give permission to obtain or release necessary information on the above child.
SIGNATURE OF PARENT/GUARDIAN

PLEASE RETURN TO: Sonshine Preschool & Daycare
NAME OF CHILD CARE PROGRAM

HISTORY: TO BE COMPLETED BY PHYSICIAN (THIS INFORMATION WILL BE HELD CONFIDENTIAL AND WILL BE USED ONLY FOR THE BENEFIT OF THIS CHILD).

A PRENATAL, PERINATAL AND POSTNATAL DEVELOPMENT: ANY SIGNIFICANT FINDINGS THAT COULD INFLUENCE THIS CHILD'S ADAPTATIONS TO A CHILD CARE SETTING (I.E., PHYSICAL HANDICAP, SENSORY LOSS, DEVELOPMENTAL IRREGULARITIES)?

B. ANY CHRONIC ILLNESS THAT MAY REQUIRE MEDICATION, PARTICULARLY OBSERVATIONS OR PRECAUTIONS IN A CHILD CARE SETTING (E.G., RECURRENT EAR INFECTIONS, SEIZURE DISORDER, ALLERGIES)?

C. ANY HOSPITALIZATIONS, OPERATIONS, OR SPECIAL TESTS OF WHICH A CHILD CARE PROVIDER SHOULD BE AWARE?

D. PERTINENT FAMILY, SOCIAL OR HEALTH CHARACTERISTICS?

IMMUNIZATIONS FOR CHILD CARE AGENCY ATTENDANCE

PARENT MAY SUBSTITUTE A COPY OF CHILD'S IMMUNIZATION RECORD

VACCINE	DATE	DATE	DATE	DATE	DATE	DATE
DTP/DTAP						
HIB						
DTP-HIB						
TD						
OPV OR IPV						
MMR						
HEP-B						
VARICELLA						
OTHER						

COMMUNICABLE DISEASE HISTORY / **RECOMMENDED SCREENING & TESTING OF ATTENDEES**

DISEASE	DATE OF DIAGNOSIS	LABORATORY CONFIRMATION	PHYSICIAN		DATE	METHOD	RESULT:
CHICKENPOX		NOT APPLICABLE		TB (FOR HIGH RISK CHILDREN ONLY)			
OTHER:				VISION			
				HEARING			
				SPEECH			
				HBG/HCT		NOT APPLICABLE	
				URINE		NOT APPLICABLE	
				LEAD		NOT APPLICABLE	

HEALTH ASSESSMENT: (TO BE COMPLETED BY LICENSED HEALTH PRACTITIONER)

CHILD'S NAME: ______________________________

PHYSICAL EXAM:

LENGTH/HEIGHT	WEIGHT	HEAD CIRCUMFERENCE	BLOOD PRESSURE
_____IN/CM %ILE______	______LB/KG %ILE______	_______IN/CM %ILE______	________ /________

CHECK( ) EACH LINE	NORMAL	ABNORMAL-	NEEDS FOLLOW-UP	NOT EXAMINED	CHECK EACH LINE:	NORMAL	ABNORMAL	NEEDS - FOLLOW-UP'	NOT EXAMINED
SKIN/SCALP					NOSE, THROAT, MOUTH				
NUTRITION					TEETH & GUMS				
NEUROLOGY & MUSCULAR					GLANDS INC. THYROID				
ORTHOPEDIC & SPINE					CHEST, BREASTS				
EYE					HEART, LUNGS				
EARS					ABDOMEN				
SPEECH					GENITALIA				

TEMPERMENT

COMMENTS:

___ EASY-GOING ___ AVERAGE ___ DIFFICULT

ALLERGIES: INCLUDE ALLERGIES TO FOOD, MEDICATION, OR OTHER SUBSTANCES:

A. ESTIMATE OF LEVEL OF MATURATION:

A.	INFANCY (0-2 YEARS)	EARLY: _______	MID: _______	LATE: _______
B.	MID-PRESCHOOL (2-4 YEARS)	EARLY: _______	MID: _______	LATE: _______
C.	PRESCHOOL (4 YEARS)	EARLY: _______	MID: _______	LATE: _______
D.	SCHOOL-AGE (6-10 YEARS)	EARLY: _______	MID: _______	LATE: _______
E.	ADOLESCENT (11-18 YEARS)	EARLY: _______	MID: _______	LATE: _______

COMMENTS:

B. ESTIMATE OF FUNCTIONAL CAPACITY:

	DELAYED FOR DEVELOPMENT PHASE	CONSISTENT WITH DEVELOPMENT-PHASE	ADVANCED FOR DEVELOPMENT PHASE	COMMENTS
GROSS MOTOR:				
FINE MOTOR:				
LANGUAGE SKILLS:				
SOCIAL SKILLS:				
EMOTIONAL:				

______________________________ PHYSICIAN'S SIGNATURE

______________________________ DATE OF EXAM

______________________________ PHYSICIAN'S NAME - TYPED OR PRINTED DATE

______________________________ TELEPHONE NUMBER

DATE OF NEXT SCHEDULED EXAM: ______________________________