

CHILD HEALTH ASSESSMENT

CHILD'S LAST NAME	FIRST NAME	PARENT/GUARDIAN
DATE OF BIRTH	HOME PHONE	ADDRESS
DATZYK MONTESSORI SCHOOL		
610-395-6344	LEHIGH COUNTY	WORK PHONE

I give my consent for my child's Physician and Child Care Provider to discuss my child's health concerns.

_____ SIGNATURE _____ DATE

HEALTH HISTORY AND MEDICAL INFORMATION PERTINENT TO ROUTINE CHILD CARE AND EMERGENCIES: NONE DATE OF EXAM

ALLERGIES TO FOOD OR MEDICINE: NONE

LENGTH/HEIGHT	WEIGHT	HEAD CIRCUMFERENCE	BLOOD PRESSURE
_____ IN/CM %ILE _____	_____ LB/KG %ILE _____	_____ IN/CM %ILE _____	_____ / _____

PHYSICAL EXAMINATION	NORMAL	ABNORMAL/COMMENTS
HEAD/EARS/EYES/NOSE/THROAT		
TEETH		
CARDIORESPERATORY		
ABDOMEN/GI		
GENETALIA/BREASTS		
EXTREMITIES/JOINT/BACK/CHEST		
SKIN/LYMPH NODES		
NEUROLOGIC/TONE		
DEVELOPMENTAL (E.G. DDST)		

IMMUNIZATIONS	DATE	DATE	DATE	DATE	DATE	COMMENTS
DTP/DTaP	1	2	3	4	5	
POLIO	1	2	3	4		
HIB	1	2	3	4		
HEP B	1	2	3			
MMR	1	2				
VARICELLA	1	2				
OTHER						NOTE: Ages and number of boosters may vary when immunizations start at older ages.

SCREENING TESTS	NORMAL	ABNORMAL/COMMENTS
LEAD		
ANEMIA (HGB/HCT)		
URINALYSIS (UA)		
HEARING		
VISION		

DATE OF LAST DENTIST'S EXAMINATION	NOTE: Age appropriate health services and immunizations must follow the schedule recommended by The American Academy of Pediatrics, 141 Northwest Point Blvd., Elk Grove Village, IL 60007
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HEALTH PROBLEMS OR SPECIAL NEEDS <input type="checkbox"/> NO PROBLEMS	RECOMMENDED TREATMENT/MEDICATIONS/SPECIAL CARE (ATTACH ADDITIONAL SHEETS IF NECESSARY)
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MEDICAL CARE PROVIDER:	NEXT APPOINTMENT: (MONTH/YEAR)
ADDRESS:	
PHONE:	_____ DATE _____ SIGNATURE OF PHYSICIAN OR CRNP MD DO CRNP