West Virginia Department of Health and Human Resources

CHILD HEALTH ASSESSMENT

Child's Name _____ Parent/Guardian _____

DOB ____/____/____ Home Phone _____ Address _____

Child Care Facility/School _____

Child Care Facility/School Phone _____ Work Phone _____

Note: A copy of the Health Check exam report attached to a copy of the child's immunization record may be substituted for this form.

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

Date Of Exam ____/____/____

Allergies to food or medicine:

Length/Height	Weight	Head Circumference	Blood Pressure
_____ in/cm %ile _____	_____ lbs/kg %ile _____	_____ in/cm %ile _____	_____ mmHg %ile _____

Physical Examination	Normal	Abnormal/Comments
Head/Ears/Eyes Nose/Throat		
Teeth		
Cardiorespiratory		
Abdomen/GI		
Genitalia/Breasts		
Extremities/Joints/Back/Chest		
Skin/Lymph Nodes		
Neurologic/Tone		
Developmental(e.g. ddst)		

Immunization	Birth to 1 Month	2 Month	4 Month	6 Month	12-18 Month	4-6 Years
DTP/DTaP						
Polio						
HIB						
HEP. B.						
MMR						
Varicella						
Other (PCV7)						

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 schedule recommended by AAP

Health Problems or Special Needs	Recommended Treatment/Medications/Special Care (Attach additional sheets if necessary)

Medical Care Provider

Address

Phone

MD
DO
PA
CRNP

Date **Signature of Physician or CRNP**

ECE-CC-3
12/04