Parent/Provider fill in this part.

Parents may write immunization dates; health professional should verify and complete all data.

CHILD HEALTH REPORT

(55 PA CODE §§3270.131, 3280.131 AND 3290.131)

		•		-			
CHILD'S NAME: (LAST)	(F	IRST)		PARENT/GU	ARDIAN:		
DATE OF BIRTH:	Н	DME PHONE: ADDRESS		ADDRESS:			
CHILD CARE FACILITY NAME:							
FACILITY PHONE:	OUNTY: WORK I			ONE:			
☐ I authorize the child care staff and my child's health professional to communicate directly if needed to clarify information on this form about my child.							
PARENT'S SIGNATURE:							
DO NOT OMIT ANY INFORMATION							
This form may be updated by a health professional. Initial and date any new data. The child care facility needs a copy of the form.							
HEALTH HISTORY AND MEDICAL INFORMATION PERTINENT TO ROUTINE CHILD CARE AND DIAGNOSIS/TREATMENT IN EMERGENCY (DESCRIBE, IF ANY): □ NONE							
DESCRIBE ALL MEDICATION AND ANY SPECIAL DIET THE CHILD RECEIVES AND THE REASON FOR MEDICATION AND SPECIAL DIET. ALL MEDICATIONS A							
CHILD RECEIVES SHOULD BE DOCUMENTED IN THE EVENT THE CHILD REQUIRES EMERGENCY MEDICAL CARE. ATTACH ADDITIONAL SHEETS IF NECESSARY. NONE							
CHILD'S ALLERGIES (DESCRIBE, IF ANY): □ NONE							
LIST ANY HEALTH PROBLEMS OR SPECIAL NEEDS AND RECOMMENDED TREATMENT/SERVICES. ATTACH ADDITIONAL SHEETS IF NECESSARY TO DESCRIBE THE PLAN FOR CARE THAT SHOULD BE FOLLOWED FOR THE CHILD, INCLUDING INDICATION OF SPECIAL TRAINING REQUIRED FOR STAFF, EQUIPMENT AND PROVISION FOR EMERGENCIES. □ NONE							
IN YOUR ASSESSMENT, IS THE CHILD ABLE TO PARTICIPATE IN CHILD CARE AND DOES THE CHILD APPEAR TO BE FREE FROM CONTAGIOUS OR COMMUNICABLE DISEASES? U YES UNO IF NO, PLEASE EXPLAIN YOUR ANSWER:							
HAS THE CHILD RECEIVED ALL AGE APPRO SCREENINGS LISTED IN THE ROUTINE PRE HEALTH CARE SERVICES CURRENTLY RECO BY THE AMERICAN ACADEMY OF PEDIATRIO SCHEDULE AT WWW.AAP.ORG)	NOTE BELOW IF THE RESULTS OF VISION, HEARING OR LEAD SCREENINGS WERE ABNORMAL. IF THE SCREENING WAS ABNORMAL, PROVIDE THE DATE THE SCREENING WAS COMPLETED AND INFORMATION ABOUT REFERRALS, IMPLICATIONS OR ACTIONS RECOMMENDED FOR THE CHILD CARE FACILITY.						
□ YES □ NO		VISION (subjective until age 3)					
		HEARING (subjective until age 4)					
		LEAD					
RECORD DATES OF IMMUNIZATIONS BELOW OR ATTACH A PHOTOCOPY OF THE CHILD'S IMMUNIZATION RECORD							
IMMUNIZATIONS	DATE	DATE	DATE	DATE	DATE	COMMENTS	
HEP-B							
ROTAVIRUS							
DTAP/DTP/TD							
HIB							
PNEUMOCOCCAL							
POLIO							
INFLUENZA							
MMR							
VARICELLA							
HEP-A							
MENINGOCOCCAL							
OTHER							
MEDICAL CARE PROVIDER:	l	<u> </u>			SIGNATURE	OF PHYSICIAN, CRNP OR PHYSICIAN'S ASSISTANT	
ADDRESS:					TITLE:		
PHONE:					LICENSE NU	MBER: DATE FORM SIGNED:	