

CHILD HEALTH FORM
(To Be Completed By Parent or Guardian)

Child's Last Name _____ First _____ M.I. _____ Birth Date: _____ / _____ / _____
 Mo Day Year
 Child's Address _____ City _____ State _____ Zip _____

We/I _____ give permission to obtain/release medical information on the above child.
 Signature of Parent/Guardian

Please return to: **Litchfield Little School, 8 Cutler Road, Litchfield, NH 03052 Phone: (603) 881-5888**

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 CHILDCARE 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			
				HIB/HCT		NOT APPLICABLE	
				Urine		NOT APPLICABLE	
				Lead		NOT APPLICABLE	

HEALTH ASSESSMENT: TO BE COMPLETED BY LICENSED HEALTH PRACTITIONER

PHYSICAL EXAM:

Length/Height ____ in/cm %ILE ____	Weight ____ lb/kg %ILE ____	Head Circumference ____ in/cm %ILE ____	Blood Pressure ____/____
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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 (incl Thyroid)				
Orthopedic & Spne					Chest, Breasts				
Eyes					Heart, Lungs				
Ears					Abdomen				
Speech					Genitalia				

TEMPERAMENT: ____ Easy-Going ____ Average ____ Difficult

Comments:

ALLERGIES: (Include allergies to food, medication or other substances)

ASSESSMENT OF PHYSICAL DEVELOPMENT:

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. Adolscnt (11-18 years) Early: ____ Mid: ____ Late: ____

Comments:

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:				

Physicians Signature

Date of Exam

Physicians Name (Typed or Printed)

Telephone Number

Date of Next Scheduled Exam: _____