

PART I - HEALTH ASSESSMENT

To be completed by parent or guardian

Child's Name: _____			Birth date: _____		Sex M ☐ F ☐
Address: _____ _____ _____			_____ _____ _____		_____ _____ _____
Number		Street	Apt#	City	State Zip
Parent/Guardian Name(s)		Relationship	Phone Number(s)		
			W: _____	C: _____	H: _____
			W: _____	C: _____	H: _____
Medical Care Provider Name: _____ Address: _____ Phone: _____		Health Care Specialist Name: _____ Address: _____ Phone: _____	Dental Care Provider Name: _____ Address: _____ Phone: _____	Health Insurance ☐ Yes ☐ No Child Care Scholarship ☐ Yes ☐ No	Last Time Child Seen for Physical Exam: Dental Care: Specialist:
ASSESSMENT OF CHILD'S HEALTH - To the best of your knowledge has your child had any problem with the following? Check Yes or No and provide a comment for any YES answer.					
	Yes	No	Comments (required for any Yes answer)		
Allergies	☐	☐			
Asthma or Breathing	☐	☐			
ADHD	☐	☐			
Autism Spectrum Disorder	☐	☐			
Behavioral or Emotional	☐	☐			
Birth Defect(s)	☐	☐			
Bladder	☐	☐			
Bleeding	☐	☐			
Bowels	☐	☐			
Cerebral Palsy	☐	☐			
Communication	☐	☐			
Developmental Delay	☐	☐			
Diabetes Mellitus	☐	☐			
Ears or Deafness	☐	☐			
Eyes	☐	☐			
Feeding/Special Dietary Needs	☐	☐			
Head Injury	☐	☐			
Heart	☐	☐			
Hospitalization (When, Where, Why)	☐	☐			
Lead Poisoning/Exposure	☐	☐			
Life Threatening/Anaphylactic Reactions	☐	☐			
Limits on Physical Activity	☐	☐			
Meningitis	☐	☐			
Mobility-Assistive Devices if any	☐	☐			
Prematurity	☐	☐			
Seizures	☐	☐			
Sensory Impairment	☐	☐			
Sickle Cell Disease	☐	☐			
Speech/Language	☐	☐			
Surgery	☐	☐			
Vision	☐	☐			
Other _____	☐	☐			
Does your child take medication (prescription or non-prescription) at any time? and/or for ongoing health condition? ☐ No ☐ Yes, If yes, attach the appropriate form.					
Does your child receive any special treatments? (Nebulizer, EPI Pen, Insulin, Blood Sugar check, Nutrition or Behavioral Health Therapy / Counseling etc.) ☐ No ☐ Yes If yes, attach the appropriate form and Individualized Treatment Plan					
Does your child require any special procedures? (Urinary Catheterization, Tube feeding, Transfer, Ostomy, Oxygen supplement, etc.) ☐ No ☐ Yes, If yes, attach the appropriate form and Individualized Treatment Plan					
I GIVE MY PERMISSION FOR THE HEALTH PRACTITIONER TO COMPLETE PART II OF THIS FORM. I UNDERSTAND IT IS FOR CONFIDENTIAL USE IN MEETING MY CHILD'S HEALTH NEEDS IN CHILD CARE.					
I ATTEST THAT INFORMATION PROVIDED ON THIS FORM IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE AND BELIEF.					
Printed Name and Signature of Parent/Guardian _____					