

PART II - CHILD HEALTH ASSESSMENT

To be completed **ONLY** by Health Care Provider

Child's Name: _____ Last First Middle				Birth Date: _____ Month / Day / Year				Sex M ☐ F ☐	
1. Does the child named above have a diagnosed medical, developmental, behavioral or any other health condition? ☐ No ☐ Yes, describe: _____									
2. Does the child receive care from a Health Care Specialist/Consultant? ☐ No ☐ Yes, describe: _____									
3. Does the child have a health condition which may require EMERGENCY ACTION while he/she is in child care? (e.g., seizure, allergy, asthma, bleeding problem, diabetes, heart problem, or other problem) If yes, please DESCRIBE and describe emergency action(s) on the emergency card. ☐ No ☐ Yes, describe: _____									
4. Health Assessment Findings									
Physical Exam	WNL	ABNL	Not Evaluated	Health Area of Concern	NO	YES	DESCRIBE		
Head	☐	☐	☐	Allergies	☐	☐			
Eyes	☐	☐	☐	Asthma	☐	☐			
Ears/Nose/Throat	☐	☐	☐	Attention Deficit/Hyperactivity	☐	☐			
Dental/Mouth	☐	☐	☐	Autism Spectrum Disorder	☐	☐			
Respiratory	☐	☐	☐	Bleeding Disorder	☐	☐			
Cardiac	☐	☐	☐	Diabetes Mellitus	☐	☐			
Gastrointestinal	☐	☐	☐	Eczema/Skin issues	☐	☐			
Genitourinary	☐	☐	☐	Feeding Device/Tube	☐	☐			
Musculoskeletal/orthopedic	☐	☐	☐	Lead Exposure/Elevated Lead	☐	☐			
Neurological	☐	☐	☐	Mobility Device	☐	☐			
Endocrine	☐	☐	☐	Nutrition/Modified Diet	☐	☐			
Skin	☐	☐	☐	Physical illness/impairment	☐	☐			
Psychosocial	☐	☐	☐	Respiratory Problems	☐	☐			
Vision	☐	☐	☐	Seizures/Epilepsy	☐	☐			
Speech/Language	☐	☐	☐	Sensory Impairment	☐	☐			
Hematology	☐	☐	☐	Developmental Disorder	☐	☐			
Developmental Milestones	☐	☐	☐	Other:	☐	☐			
REMARKS: (Please explain any abnormal findings.) _____									
5. Measurements		Date		Results/Remarks					
Tuberculosis Screening/Test, if indicated									
Blood Pressure									
Height									
Weight									
BMI % tile									
Developmental Screening									
6. Is the child on medication? ☐ No ☐ Yes, indicate medication and diagnosis: Medication Authorization Form must be completed to administer medication in child care).									
7. Should there be any restriction of physical activity in child care? ☐ No ☐ Yes, specify nature and duration of restriction: _____									
8. Are there any dietary restrictions? ☐ No ☐ Yes, specify nature and duration of restriction: _____									
9. RECORD OF IMMUNIZATIONS – MDH 896 or other official immunization document (e.g. military immunization record of immunizations) is required to be completed by a health care provider <u>or</u> a computer generated immunization record must be provided.									
10. RECORD OF LEAD TESTING - MDH 4620 or other official document is required to be completed by a health care provider.									
Under Maryland law, all children younger than 6 years old who are enrolled in child care must receive a blood lead test at 12 months and 24 months of age. Two tests are required if the 1st test was done prior to 24 months of age. If a child is enrolled in child care during the period between the 1st and 2nd tests, his/her parents are required to provide evidence from their health care provider that the child received a second test after the 24 month well child visit. If the 1st test is done after 24 months of age, one test is required.									

Additional Comments: _____

Health Care Provider Name (Type or Print):	Phone Number:	Health Care Provider Signature:	Date:
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