

# PART I - HEALTH ASSESSMENT

To be completed by parent or guardian

<b>Child's Name:</b> _____			<b>Birth date:</b> _____		<b>Sex</b> M <input type="checkbox"/> F <input type="checkbox"/>
Last                      First                      Middle			Mo / Day / Yr		
<b>Address:</b> _____					
Number      Street		Apt#	City	State	Zip
<b>Parent/Guardian Name(s)</b>		<b>Relationship</b>	<b>Phone Number(s)</b>		
		W: _____	C: _____	H: _____	
		W: _____	C: _____	H: _____	
<b>Your Child's Routine Medical Care Provider</b>		<b>Your Child's Routine Dental Care Provider</b>		<b>Last Time Child Seen for</b>	
<b>Name:</b> _____		<b>Name:</b> _____		<b>Physical Exam:</b> _____	
<b>Address:</b> _____		<b>Address:</b> _____		<b>Dental Care:</b> _____	
<b>Phone #</b> _____		<b>Phone</b> _____		<b>Any Specialist:</b> _____	
<b>ASSESSMENT OF CHILD'S HEALTH</b> - 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.					
	<b>Yes</b>	<b>No</b>	<b>Comments (required for any Yes answer)</b>		
Allergies (Food, Insects, Drugs, Latex, etc.)	<input type="checkbox"/>	<input type="checkbox"/>			
Allergies (Seasonal)	<input type="checkbox"/>	<input type="checkbox"/>			
Asthma or Breathing	<input type="checkbox"/>	<input type="checkbox"/>			
Behavioral or Emotional	<input type="checkbox"/>	<input type="checkbox"/>			
Birth Defect(s)	<input type="checkbox"/>	<input type="checkbox"/>			
Bladder	<input type="checkbox"/>	<input type="checkbox"/>			
Bleeding	<input type="checkbox"/>	<input type="checkbox"/>			
Bowels	<input type="checkbox"/>	<input type="checkbox"/>			
Cerebral Palsy	<input type="checkbox"/>	<input type="checkbox"/>			
Coughing	<input type="checkbox"/>	<input type="checkbox"/>			
Communication	<input type="checkbox"/>	<input type="checkbox"/>			
Developmental Delay	<input type="checkbox"/>	<input type="checkbox"/>			
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>			
Ears or Deafness	<input type="checkbox"/>	<input type="checkbox"/>			
Eyes or Vision	<input type="checkbox"/>	<input type="checkbox"/>			
Feeding	<input type="checkbox"/>	<input type="checkbox"/>			
Head Injury	<input type="checkbox"/>	<input type="checkbox"/>			
Heart	<input type="checkbox"/>	<input type="checkbox"/>			
Hospitalization (When, Where)	<input type="checkbox"/>	<input type="checkbox"/>			
Lead Poison/Exposure complete DHMH4620	<input type="checkbox"/>	<input type="checkbox"/>			
Life Threatening Allergic Reactions	<input type="checkbox"/>	<input type="checkbox"/>			
Limits on Physical Activity	<input type="checkbox"/>	<input type="checkbox"/>			
Meningitis	<input type="checkbox"/>	<input type="checkbox"/>			
Mobility-Assistive Devices if any	<input type="checkbox"/>	<input type="checkbox"/>			
Prematurity	<input type="checkbox"/>	<input type="checkbox"/>			
Seizures	<input type="checkbox"/>	<input type="checkbox"/>			
Sickle Cell Disease	<input type="checkbox"/>	<input type="checkbox"/>			
Speech/Language	<input type="checkbox"/>	<input type="checkbox"/>			
Surgery	<input type="checkbox"/>	<input type="checkbox"/>			
Other	<input type="checkbox"/>	<input type="checkbox"/>			
<b>Does your child take medication (prescription or non-prescription) at any time? and/or for ongoing health condition?</b>					
<input type="checkbox"/> No <input type="checkbox"/> Yes, name(s) of medication(s): _____					
<b>Does your child receive any special treatments?</b> (Nebulizer, EPI Pen, Insulin, Counseling etc.)					
<input type="checkbox"/> No <input type="checkbox"/> Yes, type of treatment: _____					
<b>Does your child require any special procedures?</b> (Urinary Catheterization, G-Tube feeding, Transfer, etc.)					
<input type="checkbox"/> No <input type="checkbox"/> Yes, what procedure(s): _____					
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.					
<b>I ATTEST THAT INFORMATION PROVIDED ON THIS FORM IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE AND BELIEF.</b>					
Signature of Parent/Guardian _____			Date _____		