Parents & Child Gare Providers fill-in this part.

Parents may write immunization dates, health professionals should verify and complete all data.

Phone:

		·	Child Hea	alth Asses				
Child's Name: (Last)		(First)		Parent/Guardian:				
Date of Birth:		Home Phone:		Address:				
Child Care Facility	/ Name:	I	•					
Facility Phone:		County:		Work Phone:				
To Parents: Submis	sion of this form to	the child care prov	ider implies consent i	for the child care prov	ider to discuss the child	s health with the child	s-clinician	
PA child care p	roviders must	document that	enrolled children	n have received	age appropriate he	ealth services and	immunizations	
that meet the c	urrent schedule	e of the Americ	an Academy of	Pediatrics 141 N	lorthwest Point Blv	d., Elk Grove Vill	age, IL 60007. The	
schedule is ava	ilable at <www< td=""><td>/.aap.org> or F</td><td>axback 847/758</td><td>I-0391 (documer</td><td>nt #9535 and #980</td><td>7). Print copies p</td><td>provided by DPW</td></www<>	/.aap.org> or F	axback 847/758	I-0391 (documer	nt #9535 and #980	7). Print copies p	provided by DPW	
have the sched	ule on the bac	k of the form.			•			
Health history and	l medical informa	ition perlinent to	routine child care a	and emergencies	Date of most recent	well-child exam:		
(describe, if any):		•	•					
Allergies to food o	r medicine (desc	ribe, if any):	· · · · · · · · · · · · · · · · · · ·		Do not omit any i	nformation. This	form may be	
•	•			updated by health professional. (Initial and date new				
NONE.			•		data.) Child care facility needs 2 copies.			
LENGTH	HEIGHT	WE	IGHT		UNFERENCE			
11.1103.6	% ILE	LEWS	01 H F		to Age 2)	(Begin	ning at age 3)	
in/cm	A	LB/KG	% ILE	IN/CM	% ILE	Amaniki Pista	/ Nacionalista del 253486	
- 31-11-Carrent - 1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-		Alien 法言意	☑ / NORMAL	THE PROPERTY OF	##ABNORMA	CACOMMENTS	美国产业公司产业	
Head/Ears/Eyes/N	yose/inmat							
Teeth								
Cardiorespiratory	•							
Abdomen/Gl								
Genitalia/Breasts								
Extremities/Joints	~~····································							
Skin/Lymph Node				~				
Neurologic & Dev			Trivia de la managrafia				IVOS IN VINS IN SECURE INSTANCIO	
MMUNIZATIONS	DATE	DATE	DATE	WEDATE (%)	DATE	CO	MMENTS (
DTa/DTP/Td					<u></u>			
POLIO	` <u> </u>				<u></u>			
H(B					<u> </u>			
HEP B							·····	
MMR					·			
VARICELLA						-	· · · · · · · · · · · · · · · · · · ·	
PNEUMOCOCCAL			-		<u> </u>	<u> </u>		
OTHER			,	·				
SCREENIN	GAESTS	DATE T	estadone 🤲	NOTEHE	REIFRESULTS A	REPENDING	or Abnormal 👍	
LEAD		-		,				
ANEMIA (HGB/HC	<u> </u>		,					
URINALYSIS (UA) (at age 5)							
HEARING (subject	tive until age 4)							
VISION (subjective			*****		4			
PROFESSIONAL		L		数据的	建筑和新疆的	14.3.3.4.3.1.1.1.1	新州村州 (4)	
Health Problems	or Special Need	is, Recommend	led Treatment/Me	dications/Special	Care/attach addition	al sheets if necess	ar) y	
NONE		•		NEXT APPOINTMENT - MONTH/YEAR:				
Medical care Prov	lder:			Signature of Physician or CPNP:				
							•	
Address:								

License Number:

Date Form Signed:

Parents & Child Care Providers fill-in this part.

Parents may write immunization dates, health professionals should verify and complete all data.

•	,		Child Hea	alth Asses	sment				
Child's Name; (Last)		(First)		Parent/Guardian:					
	·								
Date of Birth:		Home Phone:		Address:		•			
Child Care Facility	Nama'	<u> </u>		-		•			
Office Care Flacing	HEITO.		-						
Facility Phone:		County:		Work Phone:					
To Parents' Submis	sion of this form to	the child care pro	ider imalies consent i	for the child care provider to discuss the child's health with the child's clinician					
					age appropriate he				
							ige, IL 60007. The		
					nt #9535 and #980				
have the sched							· · · · · · · · · · · · · · · · · · ·		
Health history and	medical informa	tion pertinent to	routine child care a	and emergencies	Date of most recent	well-child exam:			
(describe, if any):		- Pertinorities	reading stand one of	ind Sures Basioles	Date of motification	Tree Civic Commi	•		
NONE									
Allergies to food o	r medicine (desc	afbe, if any):		Do not omit any information. This form may be					
				updated by health professional. (initial and date new					
NONE .		•	•	data.) Child care facility needs 2 copies.					
		200an deleks ser Wis	A TOP YOU BY EAST	I "tidain a material					
LENGIH			IGH (SEASON	470.	The Address of the Ad		PRESSURE F		
IN/CM	% LE	LB/KG	% ILE	IN/CM	to Age 2) % ILE	(099;;;	ing at ago o)		
WE WELLYSIC	ALEXAMINA	TION			// WHABNORMA	L. COMMENTS	多沙洲		
Head/Ears/Eyes/N	5 36 (201) 4 32 (31)	A COLUMN THE REAL PROPERTY.	Agency (Conference)	41.140-00-141-472-411			985 P. S.		
Teeth			<u> </u>						
Cardiorespiratory		**************************************		-	+				
Abdomen/Gl	·····								
Genitalia/Breasts	And the second second					*			
Extremities/Joints/	Back/Chest								
Skin/Lymph Node:									
Neurologic & Deve		\							
		DATE	DATE	DATE	DATE	THE PERMIT	MENTS W		
DTa/DTP/Td		N. C. 35 1 1 1 2 1 2 1 2 1 2 1 2 1 2 1 2 1 2 1		TOP TO ATTACK SQUARE	174-18: 12-73-1-18-1-2-18				
POLIO .			-	***************************************					
HIB									
HEP B									
MMR					•		······································		
VARICELLA									
PNEUMOCOCCAL		,	-						
OTHER			,	,					
SCREENIN	GTESTS 💥	DATET	estaone 🎥	NOTEHE	RE IF RESULTS A	REPENDING O	R ABNORMAL		
LEAD -		-		,					
ANEMIA (HGB/HC	T)								
URINALYSIS (UA)	(at age 5)								
HEARING (subjec									
VISION (subjective					4				
PROFESSIONAL				第33 3045条	经济外共产生		经的关系		
Health Problems	or Special Need	is, Récommend	led Treatment/Me	dications/Special	Care(attach addition	al sheets if necessa	r y		
□ NONE				NEXT APPOINTMENT - MONTH/YEAR:					
Medical care Provi	der:			Signature of Physician or CPNP:					
	,			*			•		
Address:									

License Number:

Phone:

Date Form Signed: