CHILD HEALTH REPORT

(55 PA CODE §§3270.131, 3280.131 AND 3290.131)

TO BE COMPLETED BY ***PARENT / GUARDIAN:***	
CHILD'S NAME: (LAST) (FIRST) (MIDDLE)	PARENT / GUARDIAN NAME:
DATE OF BIRTH:	ADDRESS:
CHILD CARE FACILITY NAME: T.I.E.S. TOTS	
FACILITY PHONE: (215) 387-5230	CELL PHONE:
COUNTY: Philadelphia	HOME PHONE:

_____ I authorize the child care staff and my child's health professional to communicate directly if needed to clarify information

_____ I do NOT authorize the child care staff and my child's health professional to communicate directly if needed to clarify.

_____PARENT'S SIGNATURE _____DATE

TO BE COMPLETED BY ***HEALTH PROFESSIONAL***. DO NOT OMIT ANY INFORMATION.

HEALTH HISTORY AND MEDICAL INFORMATION PERTINENT TO ROUTINE CHILD CARE AND DIAGNOSIS/TREATMENT IN EMERGENCY (DESCRIBE, IF ANY): DNONE

DESCRIBE ALL MEDICATION AND ANY SPECIAL DIET THE CHILD RECEIVES AND THE REASON FOR MEDICATION AND SPECIAL DIET. ALL MEDICATIONS A CHILD RECEIVES SHOULD BE DOCUMENTED IN THE EVENT THE CHILD REQUIRES EMERGENCY MEDICAL CARE. ATTACH ADDITIONAL SHEETS IF NECESSARY.

___. NONE

CHILD'S ALLERGIES (DESCRIBE, IF ANY):

___. NONE

LIST ANY HEALTH PROBLEMS OR SPECIAL NEEDS AND RECOMMENDED TREATMENT/SERVICES. ATTACH ADDITIONAL SHEETS IF NECESSARY TO DESCRIBE THE PLAN FOR CARE THAT SHOULD BE FOLLOWED FOR THE CHILD, INCLUDING INDICATION OF SPECIAL TRAINING REQUIRED FOR STAFF, EQUIPMENT AND PROVISION FOR EMERGENCIES.

___NONE

IN YOUR ASSESSMENT, IS THE CHILD ABLE TO PARTICIPATE IN CHILD CARE AND DOES THE CHILD APPEAR TO BE FREE FROM CONTAGIOUS OR COMMUNICABLE DISEASES? DYES D NO IF NO, PLEASE EXPLAIN YOUR ANSWER:

HAS THE CHILD RECEIVED ALL AGE APPROPRIATE SCREENINGS LISTED IN THE ROUTINE PREVENTIVE HEALTH CARE SERVICES CURRENTLY RECOMMENDED BY THE AMERICAN ACADEMY OF PEDIATRICS? SEE SCHEDULE AT WWW.AAP.ORG)	NOTE BELOW IF THE RESULTS OF VISION, HEARING OR LEAD SCREENINGS WERE ABNORMAL. IF THE SCREENING WAS ABNORMAL, PROVIDE THE DATE THE SCREENING WAS COMPLETED AND INFORMATION ABOUT REFERRALS, IMPLICATIONS OR ACTIONS RECOMMENDED FOR THE CHILD CARE FACILITY.
	VISION (subjective until age 3)
	HEARING (subjective until age 4)
YES _____ NO	LEAD

RECORD DATES OF IMMUNIZATIONS BELOW OR ATTACH A PHOTOCOPY OF THE CHILD'S IMMUNIZATION RECORD

IMMUNIZATIONS	DATE	DATE	DATE	DATE	DATE	COMMENTS
HEP-B						
ROTAVIRUS						
DTAP/DTP/TD						
HIB						
PNEUMOCOCCAL						
POLIO						
INFLUENZA						
MMR						
VARICELLA						
HEP-A						
MENINGOCOCCAL						
OTHER						

MEDICAL CARE PROVIDER:	SIGNATURE OF PHYSICIAN, CRNP, OR PHYSICIAN'S ASSISTANT
ADDRESS:	TITLE
	LICENSE NUMBER:
PHONE:	DATE FORM SIGNED: