

# Child Health Form

To be completed by Parent & Physician

Return to: The Country Club for kids

50 Main Street Fremont, NH 03044

Fax: (603) 895-2234

Child's First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ M.I: \_\_\_\_\_

Child's DOB: \_\_\_/\_\_\_/\_\_\_

Child's Address: \_\_\_\_\_

I hereby give permission for The Country Club for kids to receive Medical Records/Reports regarding my child. \_\_\_\_\_ Date: \_\_\_\_\_

(parent signature)

All information obtained will be held confidential and will be used only for the benefit of this child.

**HISTORY:** To be completed by Physician

- A. Prenatal, Perinatal and postnatal development: Any significant findings that could influence this child's adaptations to a child care setting (IE: Physical handicap, sensory loss, developmental irregularities?)
  
- B. Any Chronic illness that may require medication, particularly observations or precautions in a child care setting (Ex: Recurrent ear infections, seizure disorder, allergies)?
  
- C. Any hospitalizations, operations, or special tests of which a child care provider should be aware of?
  
- D. Pertinent family, social or health characteristics?

**IMMUNIZATIONS FOR CHILD CARE ATTENDANCE:** Please attach a current print out of immunizations with date it was received or fill out the following:

Vaccine	Date	Date	Date	Date	Date	Date
DTP/DTAP	_____	_____	_____	_____	_____	_____
HIB	_____	_____	_____	_____	_____	_____
DTP-HIB	_____	_____	_____	_____	_____	_____
TD	_____	_____	_____	_____	_____	_____
OPV OR IPV	_____	_____	_____	_____	_____	_____
MMR	_____	_____	_____	_____	_____	_____
HEP-B	_____	_____	_____	_____	_____	_____
VARICELLA	_____	_____	_____	_____	_____	_____
Other	_____	_____	_____	_____	_____	_____

**COMMUNICABLE DISEASE HISTORY:**

Chicken Pox....Date of Diagnosis\_\_\_\_\_

Other:\_\_\_\_\_

\_\_\_\_\_

**RECCOMENDED SCREENING/TESTING**

TB (high risk)\_\_\_\_\_

Vision:\_\_\_\_\_ Hearing:\_\_\_\_\_

Speech:\_\_\_\_\_ HIB/HCT:\_\_\_\_\_

Urine:\_\_\_\_\_ Lead:\_\_\_\_\_

**HEALTH ASSESSMENT: To be completed by licensed health practitioner**

**PHYSICAL:**

Length/Height:\_\_\_\_\_ %\_\_\_\_\_

Head Circumference\_\_\_\_\_ Inches %\_\_\_\_\_

Weight: \_\_\_\_\_ LB %\_\_\_\_\_

Blood Pressure:\_\_\_\_\_

Check each line                      Normal Abnormal                      needs follow-up                      not examined

- Skin/Scalp
- Nose, Throat, Mouth
- Teeth & Gums
- Orthopedic
- Eyes
- Ears
- Nutrition
- Glands, INC, Thyroid
- Chest, Breasts
- Heart, Lungs
- Neurology & Muscular
- Abdomen
- Genitalia

Temperment:            \_\_\_\_\_ Easy Going                      \_\_\_\_\_ Average                      \_\_\_\_\_ Difficult

Comments:

**ASSESSMENT OF PHYSICAL DEVELOPMENT:**

**A. Estimate of Level of Maturation**

A. Infancy (0-2 yrs)                      Early:\_\_\_\_\_                      Mid:\_\_\_\_\_                      Late:\_\_\_\_\_

B. Mid-Preschool (2-4years)                      Early:\_\_\_\_\_                      Mid:\_\_\_\_\_                      Late:\_\_\_\_\_

C. Preschool (4/5 years)                      Early:\_\_\_\_\_                      Mid:\_\_\_\_\_                      Late:\_\_\_\_\_

D. School-age (6-10yrs)                      Early:\_\_\_\_\_                      Mid:\_\_\_\_\_                      Late:\_\_\_\_\_

E. Adolescent (11-18yrs)                      Early:\_\_\_\_\_                      Mid:\_\_\_\_\_                      Late:\_\_\_\_\_

**B. Estimate of functional capacity**

Gross Motor                      Delay\_\_\_\_\_                      Consistent\_\_\_\_\_                      Advanced\_\_\_\_\_

Fine Motor                      Delay\_\_\_\_\_                      Consistent\_\_\_\_\_                      Advanced\_\_\_\_\_

Language Skills                      Delay\_\_\_\_\_                      Consistent\_\_\_\_\_                      Advanced\_\_\_\_\_

Social Skills                      Delay\_\_\_\_\_                      Consistent\_\_\_\_\_                      Advanced\_\_\_\_\_

Emotional                      Delay\_\_\_\_\_                      Consistent\_\_\_\_\_                      Advanced\_\_\_\_\_

\_\_\_\_\_(Physician's Signature)

\_\_\_\_\_(Date of Exam)

\_\_\_\_\_(Physician's name printed)

\_\_\_\_\_(Office Phone #)