Child Health Form

To Be Completed by Child's Physician

Last Name _____ First Name _____ M.I. _____ DOB: Mo. / Day / Year _____ Sex _____

Child's Address

We/I _____ Give permission to obtain or release necessary information on the above child.

Please Return to: Mount Royal Academy, P.O.Box 362, Sunapee, N.H., 03782
or fax: (603) 763-5390

HISTORY: To Be completed by Physician *(This information will be held confidential and will be used only for the benefit of this child).*

A. Prenatal, perinatal and postnatal development: Any significant findings that could influence this child's adaptation to a child care setting (I.e., physical handicap, sensory loss, developmental irregularities)?

B. Any chronic illness that may require medication, particularly observations or precautions in a child care setting (e.g., recurrent ear infections, seizure disorder, **allergies)**?

C. Any hospitalizations, operations, or special tests of which a child care provider should be aware?

D. Pertinent family, social or health characteristics?

Immunizations for child care agency attendance

You may substitute a copy of your own immunization record

Vaccine	Date	Date	Date	Date	Date	Date
DTP/DTaP						
Hib						
DTP-Hib						
Td						
OPV or IPV						
MMR						
Hep-B						
Varicella						
Other						

Communicable Disease History

Disease	Date of Diagnosis	Laboratory Confirmation	Physician
Chickenpox		Not Applicable	
Other			

Recommended Screening & Testing of Attendees

	Date	Method	Result:
TB (For high risk children only)			
Vision			
Hearing			
Speech			
HIB/HCT		Not Applicable	
Urine		Not Applicable	
Lead		Not Applicable	

(Over)

Health Assessment

Physical Exam:

Height _____ Percentile _____ Weight _____ Percentile _____

Head Circumference _____ Percentile _____ Blood Pressure _____ Percentile _____

Check (x) each Line	Normal	Abnormal	Needs follow-up	Not Examined	Check (x) each line	Normal	Abnormal	Needs follow-up	Examined
Skin/Scalp					Nose, Throat, Mouth				
Nutrition					Teeth & Gums				
Neurology & Muscular					Glands incl. Thyroid				
Orthopedic & spine					Chest, Breasts				
Eyes					Heart, Lungs				
Ears					Abdomen				
Speech					Genitalia				

Temperament: ☐ Easy-going ☐ Average ☐ Difficult

Comments:

Assessment of Physical Development:

A. Estimate of level of maturation:

a. Infancy (0-2 years) Early: _____ Mid: _____ Late: _____
b. Mid-Preschool (2-4 years) Early: _____ Mid: _____ Late: _____
c. Preschool (4 years) Early: _____ Mid: _____ Late: _____
d. School-age (6-10 years) Early: _____ Mid: _____ Late: _____
e. Adolescent (11-18 years) Early: _____ Mid: _____ Late: _____

B. Estimate of functional capacity:

	Delayed for Develop. Phase	Consistent with Develop. Phase	Advanced for Develop. Phase	Comments
Gross Motor:				
Fine Motor:				
Language Skills				
Social Skills				
Emotional				

C. Impression of child's present state of health:

D. Recommendations regarding:

a. Medical needs:

b. Developmental needs

c. Family support

Physician's Signature _____ **Date of Exam:** _____

Date of Next Scheduled Exam: _____

This form was designed expressly for child care use in conjunction with the New Hampshire Pediatric Society