CenClear

Child Health Assessment - HTH - 19

Child's Name ____________________ ID# __________ Child's D.O.B. ______________

Parent / Guardian ____________________ Center/Program ______________

I give my consent for my child's physician and child care provider to discuss my child's health concerns for the next twelve months.

____________________ Signature ______________ Date

Allergies to Food or Medication: ☐ None

Date of Exam: ______________

Note: Age appropriate health services and immunizations must follow the schedule recommended by The American Academy of Pediatrics, 141 Northwest Point Blvd., Elk Grove Village, IL 60007

Length/Height	Weight	Head Circumference	Blood Pressure
_____ IN/CM %ILE _____	_____ LB/KG %ILE _____	_____ IN/CM %ILE _____	_____ / _____

Physical Examination	Normal	Abnormal/Comments
Head/Ears/Eyes/Nose/Throat		
Teeth		
Cardiorespiratory		
Abdomen/GI		
Genitalia/Breasts		
Extremities/Joints/Back/Chest		
Skin/Lymph Nodes		
Neurological/Tone		
Developmental (E.G. DDST)		

Immunizations	Date	Date	Date	Date	Date	Comments
DTP/DTaP	1	2	3	4	5	
Polio	1	2	3	4		
HIB	1	2	3	4		
Hep B	1	2	3			
MMR	1	2				
Varicella	1	2				
Pneumococcal Conjugate	1	2	3	4		
Hepatitis A	1	2				

Screening Tests	Date	Results	Abnormal/Comments
Hearing			
Vision			

Tuberculin TB Test
Date Given:

Venous Lead __________ Date __________ Results

Hemoglobin __________ Date __________ Results

Health Problems or Special Needs:

☐ None

Recommended Treatment/Medications/Special Care
(Attach additional sheets if necessary)

Medical Care Provider:

Address:

Phone:

Next Appointment: (Month/Year) ____________________

____________________ MD DO CRNP ______________

Signature of Physician or CRNP Date