## **CHILD HEALTH ASSESSMENT**

				. ——					
CHILD'S NAME: (LAST) (FIRST)				PARENT/GUARDIAN:					
DATE OF BIRTH:		HOME PHONE:	ADDRESS:						
CHILD CARE FACILITY N	IAME:								
FACILITY PHONE:		COUNTY:		WORK PHO	WORK PHONE:				
meet the currer schedule is ava	nt schedule of the illable at < www.a ule on the back o	e American Acade ap.org > or Faxba of the form.	emy of Pediatri ack 847/758-03	cs 141 No	orthwest nent #95	Point Blvd., Elk 35 and #9807).	Grove \ Print co	and immunizations that /illage, IL 60007. The pies provided by DPW	
emergencies (describe, if any):					Date of most recent well-child exam:				
NONE  Allergies to food or NONE		Do not omit any information. This form may be updated by health professional. (Initial and date new data.) Child care facility needs 2 copies.							
LENGTH/HEIGHT		WEIGHT		HEA	HEAD CIRCUMFERENCE		В	LOOD PRESSURE	
		15///2 2/ " =						BEGINNING AT AGE 3)	
IN/CM %ILE		LB/KG	%ILE	IN/CM %ILE				/	
PHYSICAL EXAMINATION		☑ =NORMAL			IF ABI	NORMAL - COMM	IENTS		
HEAD/EARS/EYES TEETH CARDIORESPIRAT ABDOMEN/GI GENITALIA/BREAS EXTREMITIES/JOII SKIN/LYMPH NODI NEUROLOGIC & D IMMUNIZATIONS DTaP/DTP/Td POLIO HIB HEP B	/NOSE/THROAT								
TEETH	CODY								
CARDIORESPIRAT	ORY								
ABDOMEN/GI GENITALIA/BREAS	TQ	<del> </del>	+						
EXTREMITIES/JOIL		<del> </del>	+						
SKIN/LYMPH NODI		1							
NEUROLOGIC & D									
IMMUNIZATIONS	DATE	DATE	DATE	DAT	E	DATE		COMMENTS	
DTaP/DTP/Td									
POLIO				1					
LUD	+								
HIB									
НЕР В									
INIINIE									
VARICELLA									
VARICELLA PNEUMOCOCCAL INFLUENZA				1					
INFLUENZA				+					
	+	<del> </del>	+	+					
	IC TESTS	DATE TEST DONE		IOTE HERE	- IE BEO	LUITO ARE DELLA	INO OD 1	DNODMAL	
	IG 12515	DATE TEST DONE		NOTE HERE	IF KES	ULTS ARE PEND	ING OR A	ADNUKWAL	
ANEMIA (HGB/HCT	7		1						
URINALYSIS (UA) at age 5)									
HEARING (subjective until age 4)									
VISION (subjective until age 3)		<u> </u>	1						
PROFESSIONAL D									
	MS OR SPECIAL N	EEDS, RECOMME	ENDED TREATM				İF	ADDITIONAL SHEETS NECESSARY)	
L NONE	VIDED:	NEXT APPOINTMENT - MONTH/YEAR: SIGNATURE OF PHYSICIAN OR CRNP:							
MEDICAL CARE PRO ADDRESS:	VIDEK:			SIGNATURE	: OF PHY	SICIAN OR CRNP:			
			<b>≣</b> :	LICENSE NUMBER:				DATE FORM SIGNED:	