

Child Health Form

To be completed by Parent & Physician
Return to: The Country Club for kids
50 Main Street Fremont, NH 03044
PH: (603) 895-2234 Fax: (603) 895-0189

Child's First Name: _____ Last Name: _____ MI: _____

Child's DOB: ____/____/____

Child's Address: _____

I hereby give permission for The Country Club for kids to receive Medical Records/Reports regarding my child: _____ (parent signature) Date: _____
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 a child care provider should be aware of?

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 _____

TB _____

OPV OR IPV _____

MMR _____

HEP-B _____

VARICELLA _____

Other _____

COMMUNICABLE DISEASE HISTORY:

Chicken Pox: Date of Diagnosis: _____
Hand/Foot/Mouth: Date of Diagnosis: _____
Fifth's Disease: Date of Diagnosis: _____
Other: _____

RECOMMENDED 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: _____ % _____ 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			

Temperament _____ Easy Going _____ Average _____ Difficult

Comments: _____

ASSESSMENT OF PHYSICAL DEVELOPMENT:

A. Estimate of Level of Maturation

- a. Infancy (0-2) Early: _____ Mid: _____ Late: _____
- b. Mid-Preschool (2-4 years) Early: _____ Mid: _____ Late: _____
- c. Preschool (4/5 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

- a. Gross Motor Delay: _____ Consistent: _____ Advanced: _____
- b. Fine Motor Delay: _____ Consistent: _____ Advanced: _____
- c. Language Skills Delay: _____ Consistent: _____ Advanced: _____
- d. Social Skills Delay: _____ Consistent: _____ Advanced: _____
- e. Emotional Delay: _____ Consistent: _____ Advanced: _____

Physician's Signature: _____

Date: _____

Physician's Name (Printed): _____

Office Phone Number: _____