West Virginia Department of Human Services

Child Health Assessment

Child's Name ____________________ Parent/Guardian ____________________
DOB ____/ / Home Phone ____________________ Address ____________________
Child Care Facility/School ____________________
Child Care Facility/School Phone ____________________ Work Phone ____________________

Note: A copy of the HealthCheck exam report attached to a copy of the child's immunization record may be substituted for this form.

Health history and medical information pertinent to routine child care and emergencies: Date of Exam BBBB/BBBB/BBBBBB

Allergies to food or medicine:

Length/Height	Weight	Head Circumference	Blood Pressure
____ in/cm ____ %ile ____	____ in/cm ____ %ile ____	____ in/cm ____ %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		
Neurologic/Tone		
Developmental (e.g. ddst)		

Immunizations	Birth to 1 Month	2 Month	4 Month	6 Month	12-18 Month	4-6 Years
DTP/DTaP						
Polio						
HIB						
HEP B						
MMR						
Varicella						
Other (PCV7)						

Note: Ages and number of boosters may vary when immunizations start at older ages.

Screening Tests (If completed)	Date	Normal	Abnormal/Comments
Lead			
Anemia (HGB/HCT)			
Urinalysis (UA)			
Tuberculosis (TB)			
Hearing			
Vision			

Date of Last Dentist's Exam

Note: Age-appropriate health services and immunizations must follow the schedule recommended by AAP.

Health Problems or Special Needs

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

Medical Care Provider

Address

Phone

MD
DO PA
CRNP

Date **Signature of Physician or CRNP**

ECE-CC-3
4/2018