CHILD HEALTH REPORT

(55 PA CODE §§3270.131, 3280.131 AND 3290.131)

Parent/Provider fill in this part.

CHILD'S NAME: (LAST)	(FIRST)	PARENT/GUARDIAN:
DATE OF BIRTH:	HOME PHONE:	ADDRESS:
CHILD CARE FACILITY NAME:		
FACILITY PHONE:	COUNTY:	WORK PHONE:

☐ I authorize the child care staff and my child's health professional to communicate directly if needed to clarify information on this form about my child.

PARENT'S SIGNATURE:

DO NOT OMIT ANY INFORMATION

This form may be updated by a health professional. Initial and date any new data. The child care facility needs a copy of the form.

HEALTH HISTORY AND MEDICAL INFORMATION PERTINENT TO ROUTINE CHILD CARE AND DIAGNOSIS/TREATMENT IN EMERGENCY (DESCRIBE, IF ANY):
☐ NONE

DESCRIBE ALL MEDICATION AND ANY SPECIAL DIET THE CHILD RECEIVES AND THE REASON FOR MEDICATION AND SPECIAL DIET. ALL MEDICATIONS A CHILD RECEIVES SHOULD BE DOCUMENTED IN THE EVENT THE CHILD REQUIRES EMERGENCY MEDICAL CARE. ATTACH ADDITIONAL SHEETS IF NECESSARY.
☐ NONE

CHILD'S ALLERGIES (DESCRIBE, IF ANY):
☐ NONE

LIST ANY HEALTH PROBLEMS OR SPECIAL NEEDS AND RECOMMENDED TREATMENT/SERVICES. ATTACH ADDITIONAL SHEETS IF NECESSARY TO DESCRIBE THE PLAN FOR CARE THAT SHOULD BE FOLLOWED FOR THE CHILD, INCLUDING INDICATION OF SPECIAL TRAINING REQUIRED FOR STAFF, EQUIPMENT AND PROVISION FOR EMERGENCIES.
☐ NONE

IN YOUR ASSESSMENT, IS THE CHILD ABLE TO PARTICIPATE IN CHILD CARE AND DOES THE CHILD APPEAR TO BE FREE FROM CONTAGIOUS OR COMMUNICABLE DISEASES?
☐ YES ☐ NO IF NO, PLEASE EXPLAIN YOUR ANSWER:

HAS THE CHILD RECEIVED ALL AGE APPROPRIATE SCREENINGS LISTED IN THE ROUTINE PREVENTIVE HEALTH CARE SERVICES CURRENTLY RECOMMENDED BY THE AMERICAN ACADEMY OF PEDIATRICS? (SEE SCHEDULE AT WWW.AAP.ORG)

☐ YES ☐ NO

NOTE BELOW IF THE RESULTS OF VISION, HEARING OR LEAD SCREENINGS WERE ABNORMAL. IF THE SCREENING WAS ABNORMAL, PROVIDE THE DATE THE SCREENING WAS COMPLETED AND INFORMATION ABOUT REFERRALS, IMPLICATIONS OR ACTIONS RECOMMENDED FOR THE CHILD CARE FACILITY.

VISION (subjective until age 3)	
HEARING (subjective until age 4)	
LEAD	

RECORD DATES OF IMMUNIZATIONS BELOW OR ATTACH A PHOTOCOPY OF THE CHILD'S IMMUNIZATION RECORD

IMMUNIZATIONS	DATE	DATE	DATE	DATE	DATE	COMMENTS
HEP-B						
ROTAVIRUS						
DTAP/DTP/TD						
HIB						
PNEUMOCOCCAL						
POLIO						
INFLUENZA						
MMR						
VARICELLA						
HEP-A						
MENINGOCOCCAL						
OTHER						

Parents may write immunization dates; health professional should verify and complete all data.

MEDICAL CARE PROVIDER:		SIGNATURE OF PHYSICIAN, CRNP OR PHYSICIAN'S ASSISTANT
ADDRESS:		TITLE:
	PHONE:	LICENSE NUMBER: DATE FORM SIGNED:

Administration and control of prescription medicines and health care procedures to be used to record permission for administration of medication to children.

PERMISSION TO GIVE MEDICATION IN CHILD CARE

(Please use one form per medication.)

The following information is to be completed by the child's health care provider:

Child's name: _____ Birthdate:_____ Weight:_____

Medication: _____ Allergies:_____

Include food and/or medication allergies

Dosage: _____ Route:_____

Specific times and dosage of medication to be given should be listed on the medication chart in child's classroom: _____

Purpose of medication: _____

Special instructions: _____

Possible side effects: _____

Start date: _____ End date:_____

_____ _____ _____

Signature of Health Care Provider *Phone Number* *Date*

The following is to be completed by the parent or guardian:

I hereby give permission for my child _____, to receive the above medication, according to the listed directions and cautions, from the Executive Director, or Director's designee who is, at a minimum, an Assistant Group Supervisor. I confirm that I have given at least one dose of the medication without any evidence of side effects or adverse reactions. I understand that it is my responsibility to provide the medication in its original container and labeled with my child's full name. I am also to supply the appropriate measuring device needed to give the accurate does of the medicine. I authorize the Director or Director Designee to contact the pharmacist or health care provider for more information about this drug, if necessary.

I usually do the following to make giving medication to my child easier: _____

_____

Amount of medication brought to Child Care: _____

_____ _____

Signature of Director/Director Designee / DATE *Signature of Parent/Guardian / DATE*

* If specific medication is listed on child's annual or age-required physical exam or on a specific doctor's note, such as this, stating the medication and dosage then that is also acceptable.

* Date & amount of medication returned to Parent: _____ *Signature of Parent/Guardian* _____