Infant, Toddler, Preschool Age – Child Health Form

HEALTH CARE PROFESSIONAL COMPLETES THIS PAGE

Child's Name: _____
Birthdate: _____ Age today: _____
Date of Exam: _____

Height/Length: _____ Weight: _____
BMI- starting at age 24 mo. _____
Head Circumference- age 2 yr. and under: _____
Blood Pressure- start @ age 3 yr.: _____
Hgb or Hct- @ 12 mo.: _____
Lead Risk Assessment: _____
Blood Lead Level: date: _____ results: _____

Sensory Screening:
Vision Assessment: _____
Vision Acuity: Right eye _____ __ Left eye _ _____ __
Hearing Assessment: Right ear _____ Left ear _____
Tympanometry (may attach results)

Developmental Screening/Surveillance:
(n = normal limits) otherwise described
Developmental screening results:
Autism screening results:
Psychosocial/behavior results:
Developmental Referral Made Today: ☐ Yes ☐ No

Exam Results: (n = normal limits) otherwise describe
HEENT
Oral/Teeth
Date of Dental exam _____
Oral Health/Dental Referral Made Today ☐ Yes ☐ No
Heart
Lungs
Stomach/Abdomen
Genitalia
Extremities, Joints, Muscles, Spine
Skin, Lymph Nodes
Neurological

Health Care Provider Comments:

Allergies

Environmental:
Medication:
Food:
Insects:
Other:

Immunization: Please attach:
☐ IDPH Certificate of Immunization
☐ IDPH Certificate of Immunization Exemption Medical
☐ IDPH Certificate of Immunization Exempt Religious
☐ TB testing completed (only for high-risk child)

Medication: Health professional authorizes that the child may receive the following medications while at the child care facility: (include over-the-counter and prescribed)

Medication Name Dosage
☐ Diaper crème:
☐ Fever or Pain reliever:
☐ Sunscreen:
☐ Other:
Other medications should be listed with written instructions for use in child care.

Referrals Made:
☐ Referred to **hawk-i** today 1-800-257-8563
☐ Other: _____

Health Care Provider Assessment Statement:
☐ The child may participate in developmentally appropriate early care/learning with **NO** health-related restrictions.
☐ The child may participate in developmentally appropriate early care/learning **with restrictions** (see comments).
☐ The child has a special needs care plan
Type of plan _____ (please attach)

Signature _____
Circle the Provider Credential Type: MD DO PA ARNP

Address: Telephone: