## Parent/Provider fill in this part.

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

## CHILD HEALTH REPORT

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

CHILD'S NAME: (LAST)	(F	TRST)		PARENT/GL	PARENT/GUARDIAN:		
DATE OF BIRTH:	Н	HOME PHONE: ADDRESS		ADDRESS:	:		
CHILD CARE FACILITY NAME:							
ACILITY PHONE: COUNTY:				WORK PHONE:			
☐ I authorize the child care staff and my child	d's health prof	essional to co	ommunicate di	rectly if need	ed to clarify in	nformation 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							
	HOULD BE F					TACH ADDITIONAL SHEETS IF NECESSARY TO ATION OF SPECIAL TRAINING REQUIRED FOR STAFF,	
IN YOUR ASSESSMENT, IS THE CHILD AN COMMUNICABLE DISEASES?  YES NO IF NO, PLEASE EXPL			CHILD CAF	RE AND DOE	S THE CHIL	D APPEAR TO BE FREE FROM CONTAGIOUS OR	
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 <u>WWW.AAP.ORG</u> )  U YES U NO		VISION (subjective until age 3)					
		HEARING (subjective until age			e 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							
нів							
PNEUMOCOCCAL							
POLIO							
INFLUENZA							
MMR							
VARICELLA							
HEP-A							
MENINGOCOCCAL							
OTHER							
MEDICAL CARE PROVIDER:					SIGNATURE	 OF PHYSICIAN, CRNP OR PHYSICIAN'S ASSISTANT	
ADDRESS:					-		
					TITLE:		
PHONE:					LICENSE NUMBER: DATE FORM SIGNED:		