Little Angels
Pre-School and Kindergarten
Learning Center

CHILD HEALTH ASSESSMENT FORM

A copy of the EPSDT exam report may be attached to the child's immunizationj record as subtitution to this form.

Child's Name, Last	Child's Name, First	Date of Birth
School/Child Care Facility		Facility Phone
Parent/Guardian		Tel. Number

Address	City	State	Zip
Employer		Tel. Number	

HEALTH HISTORY AND MEDICAL INFORMATION PERTINENT TO ROUTINE CHILD CARE AND EMERGENCIES | **DATE OF EXAM**

ALERGIES TO FOOD OR MEDICINE

LENGTH/HEIGHT		WEIGHT		HEAD CIRCUMFERENCE		BLOOD PRESSURE
❑ IN ❑ CM	PERCENTILE	❑ LBS ❑ KGS	PERCENTILE	❑ LBS ❑ KGS	PERCENTILE	/

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	DATE	DATE	DATE	DATE	DATE	DATE	DATE
DTP							
POLIO							
HIB							
HEP B							
MMR							
OTHER							

Note: Ages and number of boosters may vary when immunizations start at an older age

SCREENING TESTS	NORMAL	ABNORMAL/COMMENTS
LEAD	❑	
ANEMIA (HGB/HCT)	❑	
URINALYSIS (UA)	❑	
TUBERCULOSIS (TB)	❑	
HEARING	❑	
VISION	❑	

Date of Last Dental Examination	

Note: Age appropriate health services and immunizations must follow the schedule recommended by the American Academy of Pediatrics, 141 Northwest Point Blcd., Elk e Villiage, IL 60007.

Health Problems or Special Needs	Recommended Treatments/Medications/Special Care Attach Additional Sheets If Necessary
Medical Care Provider	**Date of Next Appointment: Month/Year**
Address	