Child Development, Inc.
2880 Pottsville-Minersville Highway
Suite 210
Minersville, PA 17954
570-544-8959 • 800-433-3370
FAX: 570-544-6915

REVISED 2019-01-07

CHILD HEALTH REPORT #14

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

Parent/Provider fills in this part.

CHILD'S NAME: (Last) (First)	PARENT/GUARDIAN NAME:
DATE OF BIRTH HOME PHONE:	ADDRESS:
Child Development Inc. - _____ CENTER	
FACILITY PHONE: (570) COUNTY: SCHUYLKILL	WORK PHONE:

☐ I authorize Child Development Inc.'s Health/Development Manager to communicate directly, if needed, to clarify information on this form about my child.

PARENT 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 by staff, equipment and provision for emergencies.
☐ None

In your assessment, is the child able to participate in preschool 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

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

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

IMMUNIZATION	DATE	DATE	DATE	DATE	DATE
HEP-B					
ROTAVIRUS					
DTAP/DPT/TD					
HIB					
PNEUMOCOCCAL					
POLIO					
INFLUENZA					
MMR					
VARICELLA					
HEP-A					
MENINGOCOCCAL					
OTHER					

TB - Date: ___/___/___ Results: _____

Please complete Dates, Value/Result	NORMAL FOR AGE	ABNORMAL	REFER FOR EVALUATION
*** NOTE: A prior Lead/Hgb Result is acceptable. ***			
LEAD Date: ___/___/___ Value: _____	☐	☐	☐
H+H Date: ___/___/___ Results: _____	☐	☐	☐
VISION Date: ___/___/___ L: _____ R:	☐	☐	☐
HEARING Date: ___/___/___ L: ____ R: ____	☐	☐	☐
TEETH	☐	☐	☐

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

Based on DPW Child Health Report as of 2011-12-07