

CHILD HEALTH ASSESSMENT FOR CHILD CARE CENTERS¹ (CHILD'S PRE-ADMISSION HEALTH EVALUATION)

Parent & Child Care Providers fill in this part

CHILD'S NAME (LAST)	(FIRST)	PARENT/GUARDIAN
DATE OF BIRTH	CHILD'S HOME PHONE	PARENT/GUARDIAN'S ADDRESS
CHILD CARE FACILITY NAME		WORK PHONE
FACILITY PHONE		CHILD CARE FACILITY HOURS AND DAYS OF OPERATION FROM _____ AM / PM _____ DAYS A WEEK

PARENT'S CONSENT (TO BE COMPLETED BY PARENT)*

Please complete a health report on the above-named child using the form below. I hereby authorize release of medical information contained in this report to the above-named Child Care Center/School.

Parent/Guardian _____ Date _____

PHYSICIAN'S REPORT (TO BE COMPLETED BY PHYSICIAN)*

Do not omit any information on this form. This form may be updated by health professional. (Initial and date new data)

Asthma; allergies to food, medicine or insect bite/sting; food restriction; other (describe, if any)* <input type="checkbox"/> NONE	If you use information from the most recent health examination or well-child exam to complete this form, please list date:		
LENGTH/HEIGHT	WEIGHT	BMI (2 YEARS & OLDER)	BLOOD PRESSURE
_____ IN/CM	_____ LB/KG	_____ VALUE Percentile for age	(Beginning at age 3) ____ / ____
PHYSICAL EXAMINATION*	<input checked="" type="checkbox"/> = NORMAL	IF ABNORMAL - COMMENTS	
HISTORY AND PHYSICAL*			
DENTAL*			
DEVELOPMENTAL*			
LANGUAGE/SPEECH*			
OTHER (INCLUDE BEHAVIORAL CONCERNS)*			

IMMUNIZATION HISTORY*: (Fill out or enclose a copy of the yellow color California Immunization Record, PM-298.)

VACCINE	DATE EACH DOSE WAS GIVEN				
	1st	2nd	3rd	4th	5th
POLIO (OPV OR IPV)*	/ /	/ /	/ /	/ /	/ /
DTP/DTaP/ DT/Td* <small>DIPHTHERIA, TETANUS AND [Acellular] pertussis or tetanus and diphtheria only</small>	/ /	/ /	/ /	/ /	/ /
MMR (MEASLES, MUMPS, AND RUBELLA)*	/ /	/ /			
HIB MENINGITIS (HAEMOPHILUS B)*	/ /	/ /	/ /	/ /	
HEPATITIS B*	/ /	/ /	/ /		
VARICELLA (CHICKENPOX)*	/ /	/ /			

SCREENING TESTS	RESULTS	DATE TEST DONE	NOTE HERE IF RESULTS ARE PENDING/ABNORMAL
LEAD			
ANEMIA (HGB/HCT) (required by WIC, HEAD START and for children who meet the CDC criteria on the reverse side)			
URINE DIPSTICK/URINALYSIS (age 4 & over)			
HEARING: AUDIOMETRIC (age 3 & over)*			
VISION: SNELLEN or equivalent (age 3)*			
SCREENING - TB RISK*	<input type="checkbox"/> Risk factors not present; TB skin test not required. <input type="checkbox"/> Risk factors present; Mantoux TB skin test performed (unless previous positive skin test documented). Communicable TB disease not present.		
*PROBLEMS OF WHICH YOU SHOULD BE AWARE INCLUDING HEALTH OR SPECIAL NEEDS, RECOMMENDED TREATMENT/ PRESCRIBED MEDICATION /SPECIAL ROUTINES/RESTRICTIONS FOR THIS CHILD: (attach additional sheets if necessary)			
<input type="checkbox"/> NONE			

*I have () have not () reviewed the above information with the parent/guardian. () Physician () Physician's Assistant () Nurse Practitioner

*Physician: _____ Date of Physical Exam: _____

*Address: _____ Date This Form Completed: _____

*Telephone: _____ Medical Provider's Signature: _____

¹ Confidential Screening Report (to be completed for children ineligible to receive Child Health Disabilities Prevention Program Services)
Developed with funding from First 5 Shasta - June 2003



ITEMS WITH ASTERISK (*) ON REVERSE SIDE REQUIRED BY COMMUNITY CARE LICENSING:

For further information contact Community Care Licensing in Chico: 530-895-5033

CALIFORNIA CHILDHOOD LEAD SCREENING REGULATIONS

- Screening is required of all children receiving services from: Medi-Cal, CHDP, Healthy Families or WIC or similar federally funded or State of California program.
Blood test for Lead at age 12 and 24 months
OR at 12-24 months if not tested at 12 months or thereafter
OR 24-72 months if circumstances change to increase risk of lead poisoning
- All other children should be assessed with this question at the same ages as above:
"DOES YOUR CHILD LIVE IN OR SPEND A LOT OF TIME IN A PLACE BUILT BEFORE 1978 THAT HAS PEELING OR CHIPPED PAINT OR HAS BEEN RECENTLY RENOVATED?"
 If the response to the above question is "Yes" or "Don't Know" a blood lead screening test should be ordered on this child at risk.

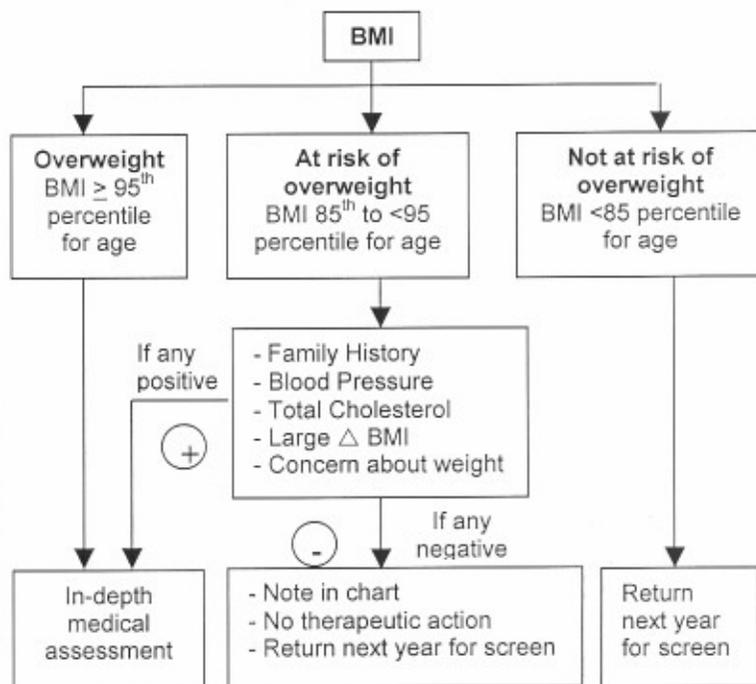
CDC 1998 ANEMIA GUIDELINES

Age (years)	Sex	Hgb	Below	Hct
0 - 1.9	Both	11.0 gm	32.9%
2 - 4.9	Both	11.1 gm	33%

CDC¹ HIGH RISK POPULATIONS AND RISK FACTORS – ANEMIA

High Risk Populations	Screening Suggestions
Children from low-income families Children eligible for WIC Migrant Children Recently arrived refugee children	Screen all between 9-12 months, then 6 months later, and annually from ages 2 to 5 years
Risk Factors Among Non-High Risk Populations	Screening Suggestions
Pre-term Infants Low birth weight infants who are not fed iron-fortified infant formula	Consider screening at 6 months
Pre-term/low birth weight infants Infants fed diet of non-iron-fortified infant formulas for >2 months Infants fed cow's milk before age 12 months Breast-fed infants who have a diet of inadequate iron after 6 months Children who drink >24 ounces daily of cow's milk or other low-iron beverage(s) (e.g., soda, fruit juice, rice milk, etc.) Children with special healthcare needs	Screen between 9-12 months, then 6 months later
Children with low iron diets Children with limited access to food due to poverty or neglect Children with special healthcare needs	Screen annually ages 2-5 years

BMI SCREENING CRITERIA



RISK FACTORS FOR TB IN CHILDREN:

- Have a family member or contacts with a history of confirmed or suspected TB.
- Are in foreign-born families and from high-prevalence countries (Asia, Africa, Central and South America).
- Live in out-of-home placements.
- Have, or are suspected to have, HIV infection.
- Live with an adult with HIV seropositivity.
- Live with an adult who has been incarcerated in the last five years.
- Live among, or are frequently exposed to, individuals who are homeless, migrant farm workers, users of street drugs, or residents in nursing homes.
- Have abnormalities on chest x-rays suggestive of TB.
- Have clinical evidence of TB.

Consult with your local health department's TB control program on any aspects of TB prevention and treatment.

¹ CDC = Center for Disease Control

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