**Health Care Summary - Child Check-Up Exam**

Child Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Gender:  M  F

Parent/Guardian Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |
| --- |
| Is child up to date with C&TC including all required tests:  Yes  No Date of last Physical: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Are Immunization up-to-date (please attach a copy):  Yes  No How long have you been seeing this child? \_\_\_\_\_\_\_\_\_\_How frequent do you see this child when he/she is not ill? \_\_\_\_\_\_\_\_\_\_\_ |
| Height: \_\_\_\_\_ in. Weight: \_\_\_\_\_ lbs.  No Concern  Concern  | Blood Pressure: \_\_\_\_\_\_/\_\_\_\_\_\_  No Concern  Concern |
| Vision Status:  No Concern  Concern  Unable  ReferR 20/ \_\_\_\_\_\_\_\_ L 20/\_\_\_\_\_\_\_\_ Corrected:  Yes  NoHearing Status:  No Concern  Concern  Unable  Refer

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | 500 (25) | 1000(20) | 2000(20) | 4000(20) |
| Right |  |  |  |  |
| Left |  |  |  |  |

 | \*Required: Previous dates acceptable

|  |  |  |  |
| --- | --- | --- | --- |
| \*Lab  | Date  |  Results  | Comments |
| \*Hemoglobin |  |  |  |
| \*Blood Lead Level |  |  |  |

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|  |
| Area  | N | AB | Comments | Area | N | AB | Comments |
| General Appearance |  |  |  | Lungs |  |  |  |
| Head |  |  |  | Abdomen |  |  |  |
| Face |  |  |  | Genitourinary |  |  |  |
| Eyes |  |  |  | Musculoskeletal |  |  |  |
| Ears |  |  |  | Spine |  |  |  |
| Mouth-Teeth |  |  |  | Extremities |  |  |  |
| Throat |  |  |  | Skin |  |  |  |
| Nose |  |  |  | Neurological |  |  |  |
| Neck |  |  |  | Nutritional Status |  |  |  |
| Cardiovascular |  |  |  | Emotional Status |  |  |  |
| Chest |  |  |  | Speech+ty |  |  |  |

Allergies:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Routine Medications:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is child developing appropriately for his/her age?  No  Yes, please specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is a special diet necessary?  No  Yes, please identify restrictions: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is there a condition present which may result in an emergency?  No  Yes, please specify:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is there a condition that may interfere with learning?  No  Yes, please specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please indicate any present important health conditions followed by you: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any present important health conditions followed by another health care provider?  No  Yes, please specify condition and name of health care provider: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does this important health condition require special attention at the child care program?  No  Yes, please specify:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any restrictions, recommendations, or other information helpful to the child care program: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Health Care Provider (sign):** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **\*Physical Exam Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Date Signed:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Clinic Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Montessori American Indian Childcare Center Office Use:** Date of Enrollment: \_ Date Form was Received: \_\_\_\_\_\_\_\_\_\_\_\_\_