**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  Refer  R 20/ \_\_\_\_\_\_\_\_ L 20/\_\_\_\_\_\_\_\_ Corrected:  Yes  No  Hearing 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 |  |  |  | | | | |
|  | | | | | | | | |
| 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: \_\_\_\_\_\_\_\_\_\_\_\_\_