PART I – CHILD HEALTH HISTORY – to be completed by *MD/DO/APN/NP/PA*

Physician (MD or DO), Advanced Practice Nurse (APN), Nurse Practitioner (NP), or Physician's Assistant (PA)

Name:_____ **Gender:**_____ **DOB:**_____

Date:_____ **Examiner:**_____

PART I	HEALTHCARE PROVIDER COMMENT
Developmental delay (speech, ambulation, other)?	
Serious injury or illness?	
Medication?	
Allergies (food, insect, other)?	
Diagnosis of asthma?	
Diabetes?	
Seizures?	
ADHD/ADD?	
Behavior concerns?	
Other diagnoses?	

PART II – IMMUNIZATIONS – to be completed by *MD/DO/APN/NP/PA*

Printed Vaccination Administration Record (VAR) form may be attached in lieu of completion.

DTP/Hib 1 / /	DTP/Hib 2 / /	DTP/Hib 3 / /	DTP/Hib 4 / /	DTaP/Hib 4 / /
DTP/DTaP 1/ DT / /	DTP/DTaP 2/ DT / /	DTP/DTaP 3/ DT / /	DTP/DTaP 4/ DT / /	DTP/DTaP 5/ DT / /
Td 1 / /	Td 2 / /	Td 3 / /	MMR 1 / /	MMR 2 / /
OPV/IPV 1 / /	OPV/IPV 2 / /	OPV/IPV 3 / /	OPV/IPV 4 / /	Hep B 1 / /
Hep B 2 / /	Hep B 3 / /	Hib 1 / /	Hib 2 / /	Hib 3 / /
Hib 4 / /	Hep B/Hib 1 / /	Hep B/Hib 2 / /	Hep B/Hib 3 / /	Varicella 1 / /
Varicella 2 / /	Pneumococcal Polysaccharide 1 / /	Pneumococcal Polysaccharide 2 / /	Pneumococcal Conjugate 1 / /	Pneumococcal Conjugate 2 / /
Pneumococcal Conjugate 3 / /	Pneumococcal Conjugate 4 / /	Hep A 1 / /	Hep A 2 / /	Influenza 1 / /
Influenza 2 / /	Lyme Vax 1 / /	Lyme Vax 2 / /	Lyme 3 / /	Other: / /

PART III – SCREENING & TESTING – to be completed by *MD/DO/APN/NP/PA*

Screen	**Comprehensive Physical Exam Completed:** ☐**Yes** ☐**No** **Date of Exam:** _____ **Height:** _____ **Weight:** _____ **BP:** _____ **Pulse:** _____ **Other:**_____ (inches) (pounds)

Dental Screen	☐ **Problem Identified:** Referred for treatment ☐Yes ☐No ☐ **No Problem:** Referred for prevention ☐Yes ☐No ☐ **No Referral:** Already receiving dental care ☐Yes ☐No
Tuberculosis Screen	All new entrants must have TB test or TB Risk Assessment completed within 12 months prior to school entry. **Risk Assessment:** **Date**_____ **Results**: ☐ Test Required ☐ Test Not Required **Mantoux Skin Test:** **Date**_____ **Results**:_____MM **Other:** (type)_____ **Date**_____ **Results**:_____MM
Other Screen	**Hearing:** **Type**:_____ **Date**:_____ **Results**:_____ **Referral:** ☐ No ☐ Yes _____ Date **Vision:** **Type**:_____ **Date**:_____ **Results**:_____ **Referral:** ☐ No ☐ Yes _____ Date **Other:** **Type**:_____ **Date**:_____ **Results**:_____ **Referral:** ☐ No ☐ Yes _____ Date
Lead Screening	**Blood Lead Screening 12 months:** **Date:** _____ **Value:** _____ **Blood Lead Screening 24 months:** **Date:** _____ **Value:** _____

☐ **Not Applicable for this Child**

FOR CHRONIC & LIFE-THREATENING CONDITIONS:

Children with life-threatening conditions need an emergency child care plan.
Please attach child care plan, protocols, and/or emergency child care plan.

Recommendations or Referrals: _____

DIAGNOSIS	EMERGENCY PLAN ATTACHED		CARE PLAN OR PRESCRIPTION PLAN ATTACHED	
	YES	NO	YES	`NO

Print Name: _____ **Signature:** _____ **Date:** _____

☐ Physician (MD or DO) ☐ Advanced Practice Nurse (APN) ☐ Nurse Practitioner (NP) ☐ Physician Assistant (PA)

Address: _____ **Phone:** _____