Child Health Appraisal Form

Date: ____________ Child: ________________________________ Gender: M F (circle one)

Date of Birth: _____________ Address: ____

Phone: ____________________ City, ST Zip: ____

Date of Exam____________________

1. General review of health history:	2. Medical information pertinent to diagnosis and treatment in case of emergency:
3. Special instructions to provider regarding any medications required during child care:	4. Recommended modifications or limitations of child's activity or diet:
5. Vision: _____Normal _____Abnormal Comments:________________________________	6. Hearing/Auditory or equivalent subjective Screening ___________________(date) Audiometry__________________(date)
7. Growth measurement: Height_______ Percentile_______ Weight_______ Percentile_______	8. HGB: _____Normal _____Abnormal
9. GM or HCT% _____Normal _____Abnormal	10. Blood Pressure: _____Normal _____Abnormal
11. Medical: (see table below)	12. Developmental appraisal: Is the child progressing normally within his/her age or group? _____Yes _____No

11. Medical:

	Normal	Abnormal
Abdomen		
Cardiovascular		
Ears, Nose		
Eyes		
Extremities, Joints		
Genetalia, Breasts		
Lungs		
Mouth, Throat		
Skin, Lymph Nodes		
Spine		

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Physician's Signature Printed Name Date

Physician's Mailing Address: ____

Phone: ____________________ City, ST Zip: ____