NAME__________________________ STATE OF DELAWARE Zion Early Education Center

DEPARTMENT OF SERVICES FOR CHILDREN,
YOUTH AND THEIR FAMILIES
OFFICE OF CHILD CARE LICENSING

BIRTHDATE___________________

CHILD HEALTH APPRAISAL

SECTION A: TO BE COMPLETED BY PARENT BEFORE PHYSICAL EXAMINATION

CHECK IF CHILD HAS PROBLEMS WITH ANY OF THE FOLLOWING: GIVE ADDITIONAL COMMENTS BELOW

__Allergies (food, medicine, bee sting etc.) __ Frequent Colds __ Fainting __ Physical Handicap
__ Hearing Difficulty __ Speech Difficulty __ Behavior Problem
__Constipation/Diarrhea __ Seizures __ Vision Difficulty __ Asthma

Other____

Comments:____

ADDITIONAL INFORMATION ABOUT YOUR CHILD (include serious illness, accidents, operations, medications, etc. with dates):
____
____

Parent/Guardian's Signature____Date________________________

SECTION B: TO BE COMPLETED BY EXAMINING PHYSICIAN/PEDIATRIC NURSE PRACTITIONER

CODE: X - Within Normal Limits O - See Remarks Below

___Scalp, Skin ___Heart ___Vision ___Ear, Nose ___Lungs
___Hearing ___Throat ___Abdomen ___Blood Pressure ___Eyes
___Genitalia ___Teeth ___Extremities ___Neck, Glands ___Nervous System
___Height ___Weight

REMARKS AND RECOMMENDATIONS:____
____

IS CHILD PROGRESSING NORMALLY FOR AGE GROUP C____

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 / /	/ /	/ /
OPV/IPV I / /	OPV/IPV 2 / /	OPV/IPV 3 / /	OPV/IPV 4 / /	TB Screening 12 mo / /
MMR 1 / /	MMR2 / /	HepB / /	HepB 2 / /	HepB 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 / /	Influenza 1 / /
Influenza 2 / /	Pneumococcall Polysaccharide 1 / /	Pneumococcal Polysaccharide 2 / /	Pneumococcal Conjugate 1 / /	Pneumococcal Conjugate 2 / /
Pneumococcal Conjugate 3 / /	Pneumococcal Conjugate 4 / /	Hep A 1 / /	Hep A 2 / /	Lyme Vax 1 / /
Lyme Vax 2 / /	Lyme Vax 3 / /	Other: / /	Lead Screening 12 mo / /	

Examiner's signature____ __ M.D. __P.N.P. Date:______________________________

Printed Name:____Telephone:____________________________________

My permission is given for my child's physician to provide an authorized representative of Zion Early Education Center with any medical information which would be helpful in the care of my child.

Parent's Signature: ____