

Infant, Toddler, Preschool Age – Child Health Exam Form

PARENTS COMPLETE PAGES 1 and 2 – child information

Child's name		Child's birthdate	Name of center, provider, or preschool
			Telephone #
Parent 1 name		Parent 2 name	
Child home address #1		Telephone # 1	
Child home address #2		Telephone #2	
Where parent # 1 works	Work address	Home phone # Work # Pager # Cellular # Home email Work email	
Where parent # 2 works	Work address	Home phone # Work # Pager # Cellular # Home email Work email	
In the event of an emergency, the child care provider is authorized to obtain EMERGENCY MEDICAL or DENTAL CARE even if the child care center is unable to immediately make contact with the parents/guardian. During an emergency the child care provider is authorized to contact the following person when parent or guardian can not be reached.			
Parent/Guardian Signature: _____		Date _____	
Alternate emergency contact person's name:		Relationship to child:	Phone number:
Child's doctor's name		Doctor telephone # 1	Hospital choice
Doctor's address		After hours telephone #	Does your child have health insurance? <input type="checkbox"/> Yes, Company _____ ID #
Child's dentist's name		Dentist Telephone # 1	Does your child have dental insurance? <input type="checkbox"/> Yes, Company _____ ID#
Dentist's Address		After hours telephone #	<input type="checkbox"/> NO, we do not have health insurance. <input type="checkbox"/> NO, we do not have dental insurance.
Other health care specialist name		Telephone #	<input type="checkbox"/> Please help us find health or dental insurance.
Type of specialty			

Child Name: _____

PARENTS COMPLETE THIS PAGE

Parents: Tell us about your child's health. Place an **X** in the box if the sentence applies to your child. Check *all* that apply to your child. This will help your doctor plan your child's physical exam.

Growth

I am concerned about my child's growth.

Appetite

I am concerned about my child's eating / feeding habits or appetite.

Rest -

I am concerned about the amount of sleep my child needs.

Illness/Surgery/Injury - My child

has had a serious illness, surgery, or injury. *Please describe.*

Physical Activity - My child

must restrict physical activity. *Please describe.*

Development and Learning

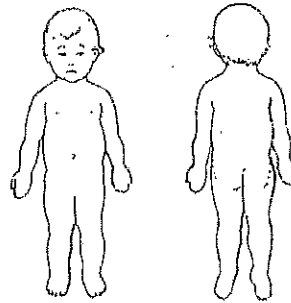
I am concerned about my child's behavior, development, or learning. *Please describe:*

Medication - My child takes medication. List meds taken at home, preschool, or in child care. List the name, time medication taken, and the reason medication prescribed.

Child's Name: _____

Body Health - My child has problems with
 Skin, birthmarks, Mongolian spots, hair, fingernails or toenails.

Map and describe any skin markings



- Eyes \ vision, glasses
- Ears \ hearing, hearing aides or device, ear-aches, tubes in ears
- Nose problems, nosebleeds, runny nose
- Mouth, teething, gums, tongue, sores in mouth or on lips, mouth-breathing, snoring
- Frequent sore throats or tonsillitis
- Breathing problems, asthma, cough, croup
- Heart, heart murmur
- Stomach aches, upset stomach, colic, spitting up
- Using toilet, toilet training, urinating
- Bones, muscles, movement, pain with moving
- Mobility, uses assistive equipment
- Nervous system, headaches, seizures, or nervous habits (like twitches)
- Needs special equipment. *Please describe:*

Allergies - My child has allergies (food, medicine, fabric, inhalants, insects, animals, etc.). Please describe.

Parent questions or comments for the health care provider: