CHILD'S NAME _____

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

Family child Care
Large Family Child Care Home
Day Care Center

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.)
- ☐ Constipation/Diarrhea
- ☐ Frequent Colds
- ☐ Hearing Difficulty
- ☐ Seizures
- ☐ Fainting
- ☐ Speech Difficulty
- ☐ Vision Difficulty
- ☐ Physical Handicap
- ☐ Behavior Problem
- ☐ 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? _____

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 1 / /	OPV/IPV 2 / /	OPV/IPV 3 / /	OPV/IPV 4 / /	TB Screening 12 mo / /
MMR 1 / /	MMR 2 / /	HepB 1 / /	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 / /	Pneumococcal Polysaccharide1 / /	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:_____

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