HEALTH ASSESSMENT

KINDERBERRY HILL
CHILD DEVELOPMENT CENTERS

****TO BE COMPLETED BY PHYSICIAN****

Child's Name	Birth Date
Address	Phone
Height (Percentile)	Weight (Percentile)

Physical Findings
A-*Abnormal*
N-*Normal*
Circle One

			Comments				Comments
Head	A	N		Cardiovascular	A	N	
Face	A	N		Abdomen	A	N	
Neck	A	N		Genitals	A	N	
Eyes	A	N		Extremities	A	N	
Ears	A	N		Joints	A	N	
Nose	A	N		Muscle Tone	A	N	
Mouth	A	N		Skin	A	N	
Throat	A	N		Neurological	A	N	
Chest	A	N		Vision	A	N	
Spine	A	N		Hearing	A	N	

Lab Findings

Hemoglobin/ Hematocrit	Urinalysis	Sickle Cell	Blood Lead	Mantoux	Other

Subjective Assessment (Infants Only)

Birth History (*please note significant information regarding premature birth, injury, etc.*)

Feeding/Nutrition (*Recommendations for the following)*

Breast	Amount	Frequency	
Formula	Type	Amount	Frequency

Solids: Type/Amount

Nutritional Supplements

Emergency Care

Does this child have allergies? Yes | No

Reaction

Recommendation

Is this a condition that may result in an emergency?

Emergency plans

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Important Health Problems

Problems	Followed by	Requires special attention in child care

How long have you been seeing this child?

Is a special diet necessary?	Yes	No
If yes, specify		

Is this child developing normally for his/her age?	Yes	No

If not, what modifications in the child care program are needed?

Additional comments

For Our Records

Name of clinic (if applicable) Phone

Address

Physician's signature Date Exam Date

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