Presbyterian Weekday Preschool
249 East Main Street, Brevard, NC 28712
Phone: (828)884-9298 FAX: (828)883-4672

CHILD HEALTH ASSESSMENT

This form must be returned to the Preschool no later than two weeks of your child's starting date. An immunization record must be included or attached.

TOP: To be filled out by parent or guardian.

Date of Exam: ______________________

CHILD'S NAME: (LAST)	(FIRST)	PARENT/GUARDIAN:
DATE OF BIRTH:	HOME PHONE:	ADDRESS:
CHILD CARE FACILITY NAME:		
CHILD CARE FACILITY PHONE:	COUNTRY:	WORK PHONE:

I give my consent for my child's physician and Child Care Provider to discuss my child's health concern.

Signature Date

BELOW: To be filled out by a physician.

HEALTH HISTORY AND MEDICAL INFORMATION PERTINENT TO ROUTINE CHILD CARE AND EMERGENCIES:

☐ NONE

ALLERGIES TO FOOD OR MEDICINE:

☐ NONE

LENGTH/HEIGHT	WEIGHT	HEAD CIRCUMFERENCE	BLOOD PRESSURE
_____IN/CM % ILE _________	______LB/KG % ILE _______	(Birth to Age 2 ________IN/CM % ILE ________	(Beginning at age 3) /

PHYSICAL EXAMINATION	✔ = NORMAL	IF ABNORMAL - COMMENTS
Head/Ears/Eyes/Noses/Throat		
Teeth		
Cardiorespiratory		
Abdomen/GI		
Genitalia/Breasts		
Extremities/Joints/Back/Chest		
Skin/Lymph Nodea		
Neurologic/Tone		
Developmental (E.G. DDST)		

IMMUNIZATIONS	DATE	DATE	DATE	DATE	DATE	COMMENTS
DTa/DTP/Td						
POLIO						
HIB						
HEP B						
MMR						
VARICELLA						
OTHER						

SCREENING TESTS	DATE TEST DONE	ABNORMAL/COMMENTS
LEAD		
ANEMIA (HGB/HCT)		
URINALYSIS (UA) (at age 5)		
HEARING (subjective until age 3)		
VISION (subjective until age 3)		
PROFESSIONAL DENTAL EXAM		Date of Last Dentist's Exam:

Health Problems or Special Needs, Recommended Treatment/Medications/Special Care (attach additional sheets if necessary)

❑ NONE NEXT APPOINTMENT - MONTH/YEAR:

Medical Care Provider:	Signature of Physician or CPNP:
Address:	
Phone:	Date: