Green Mountain Children's Center
CHILD HEALTH FORM

To be completed by parent or guardian:

_____ _____ ____ _____/_____/_____ ___ ____
Child's Last Name First Name M.I. DOB Mo Day Year Boy Girl

_____
Child's Address

We/I _____ give permission to obtain or release necessary information on the above child.

Please return to:
Green Mountain Children's Center; 92 Farm Vu Drive; White River Junction, VT 05001
Or Fax: 802-296-3117

To be completed by Physician (this information will be held confidential and will be used only for the benefit of this child)

History

A. Prenatal, perinatal and postnatal development: Any significant findings that could influence this child's adaptations to a child care setting (IE: physical handicap, sensory loss, development irregularities)?

B. Any chronic illness that may require medication, particularly observations or precautions in a child care setting (IE. Recurrent ear infections, seizure disorder, allergies)?

C. Any hospitalizations, operations or special tests of which a child care provider should be aware?

D. Pertinent family, social or health characteristics?

Vaccine	Date of 1st Dose	Date of 2nd Dose	Date of 3rd Dose	Date of 4th Dose	Date of 5th Dose
DTaP					
Hep B					
IPV/OPV					
Hib					
MMR					
Varicella					
PCV					

**Vermont Child Care regulations require that each child enrolled in child care must be immunized appropriate to age for DPT, polio, measles, rubella, mumps and HIB. However, no child is required to be immunized if immunizations are medically contraindicated or against a family's religious or moral beliefs, but an exemption form then must be filed at the child care program.

Communicable Disease History

Disease	Date of Diagnosis	Laboratory Confirmation	Physician
Chicken Pox		n/a	

Recommended Screening & Testing of Attendees

	Date	Method	Result
TB (high risk only)			
Vision			
Hearing			
Speech			
HIB/HCT		N/A	
Urine		N/A	
Lead		N/A	

Physical Exam

Length/Height	Weight	Head Circumference	Blood Pressure
_____In/CM _____%	**_____Lb/Kg _____%**	**_____In/CM _____%**	/

Check Each Line	Norman	Abnormal	Not Examined
Skin/Scalp			
Nutrition			
Neurology/Muscular			
Orthopedic & Spine			
Eye			
Ears			
Speech			
Nose, Throat			
Teeth & Gums			
Glands, Inc Thyroid			
Chest			
Heart, Lungs			
Abdomen			
Genitalia			

Temperament: _____ Easy Going? _____ Average? _____ Difficult? _____

Comments:

Assessment of Physical Development

A. Estimate of level of maturation:

Mid-Preschool (2-4 years) **Early:** _____ **Mid:** _____ **Late:** _____

Pre-School (4 years) **Early:** _____ **Mid:** _____ **Late:** _____

School-age (6-10 years) **Early:** _____ **Mid:** _____ **Late:** _____

School age (6-10 years) **Early:** _____ **Mid:** _____ **Late:** _____

B. Estimate of functional capacity:

	Delayed for Development Phase	Consistent with Development Phase	Advanced for Development Phase	Comments
Gross Motor:				
Fine Motor:				
Language:				
Social Skills:				
Emotional:				

C. Impression of Child's present state of health:

D. Recommendations regarding:

a. Medical Needs:

b. Developmental Needs:

c. Family Support:

_____ _____
Physicians Name (Print) Date of Exam

_____ _____
Physicians Signature Date of Next Scheduled Exam