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

NAME_____

BIRTHDATE_____

Family Child Care
Large Family Child Care Home
Day Care Center

# 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.) | ☐ Frequent Colds | ☐ Fainting | ☐ Physical Handicap |
| | ☐ Hearing Difficulty | ☐ Speech Difficulty | ☐ Behavior Problem |
| ☐ Constipation/Diarrhea | ☐ Seizures | ☐ Vision Difficulty | ☐ 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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