



Medical Record: Child Health Assessment

The Child Health Assessment form is to be completed and signed by a nurse approved to perform health assessments, a licensed physician, or physician's assistant (PA). The health assessment shall be conducted not more than 12 months before and no later than 60 calendar days after enrollment at the child care facility.

A Child Health Assessment, recorded on a KDHE Form or another outlined acceptable form, is required for all children including children of the provider or staff in Family Child Care Homes, Child Care Centers and Preschools. Acceptable forms include: A Kan-Be-Healthy Assessment Form (KDHE Form), a Physician Health Assessment Form and a School Health Assessment Form for school-age children or youth

Child's Name _____ **Date of Birth** _____
First Last

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|---|---|
| Health history and medical information pertinent to routine child care and emergencies (describe, if any): <input type="checkbox"/> None | Do you see this child for regular health supervision: <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Allergies to food or medicine (describe, if any): <input type="checkbox"/> None | |
| List current medications (if any): <input type="checkbox"/> None | |

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|--|--|---|
| Length/Height: _____ IN/CM %ILE _____ | Weight: _____ LB/KG %ILE _____ | |
| Physical Examination | <input checked="" type="checkbox"/> If Normal | If Abnormal - Comments |
| Head/Ears/Eyes/Nose/Throat | | |
| Teeth | | |
| Cardio/Respiratory | | |
| Abdomen/GI | | |
| Genitalia/Breasts | | |
| Extremities/Joints/Back/Chest | | |
| Skin/Lymph Nodes | | |
| Neurologic & Developmental | | |
| Screening Tests | Screening Date | Note Here if Results are Pending or Abnormal |
| Lead | | |
| Anemia (HGB/HCT) | | |
| Urinalysis (UA) | | |
| Hearing | | |
| Vision | | |

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| Health Problems or Special Needs, Recommended Treatment/Medications/Special Care (Attach additional pages if necessary) <input type="checkbox"/> None | | |
| Signature of Licensed Physician or Nurse approved for Child Health Assessment | Date | |
| Print the Name of the Individual Signing Above | Phone Number | |
| Address | City | Zip Code |