



SOUTHEAST DUBOIS COUNTY SCHOOL CORPORATION



Early Childhood Health Assessment Record

(To be filled out by parent/guardian and reviewed by your Doctor)

To Parent or Guardian: In order to provide the best experience, early childhood providers must understand your child's health needs. This form requests information from you (Part 1) which will be helpful to the health care provider when he or she completes the health evaluation (Part 2) and oral health assessment (Part 3). State law requires complete primary immunizations and a health assessment by a physician, an advanced practice registered nurse, a physician assistant, or a legally qualified practitioner of medicine, an advanced practice registered nurse or a physician assistant stationed at any military base prior to entering an early childhood program in Indiana.

(Please Print)

Child's Name (Last, First, Middle):	Birth Date: (mm/dd/yyyy)	☐ Male
		☐ Female
Address (Street, Town, ZIP code)		
Parent/Guardian Name:	Cell Phone:	Other Emergency Contact:
Primary Health Care Provider:	Phone #:	
Name of Dentist:	Interested in Mobile Dental services, organized through the school corporation during the school day? ☐	

Part 1- To be completed by parent/guardian.*Please answer these health history questions about your child before the physical examination.*

Please circle Y if "yes" or N if "no." Explain all "yes" answers in the space provided below.

Any health concerns?	Y / N	Problems breathing or coughing?	Y / N
Allergies to bee stings or insects?	Y / N	Asthma Treatment? (*)	Y / N
Food Allergies that require substitution at school? (*) ex: gluten, milk, etc	Y / N	Does your child use a rescue inhaler?	Y / N
Allergy to any Medications?	Y / N	Diabetes? (*)	Y / N
		Seizures? (*)	Y / N
Any Daily/ongoing medications? (**)	Y / N	Rescue medication for seizures or Allergies?	Y / N
ADD/ADHD	Y / N	Major illness or injury	Y / N
Anxiety/emotional/behavioral concerns	Y / N	Any operations/surgeries	Y / N
Frequent ear infections?	Y / N	Stomach/GI issues	Y / N
History of tubes?	Y / N	Toileting concerns	Y / N
Any problems with teeth?	Y / N	Any vision concerns:	Y / N
Has your child had a dental examination in the last 6 months?	Y / N Date: _____	Does your child wear glasses?	Y / N
Skin Conditions?	Y / N	Has your child had a vision examination in the last year? Date: _____	Y / N
Heart Problems?	Y / N	Other Medical Concerns	

Explain all "yes" answers to provide any additional information:

(*)- indicates that a separate, individualized Healthcare Action Plan will need to be filled out and on file in the clinic. The action plans are reviewed every year. Paperwork must be completed at the beginning of each school year & modified as needed.

(**) Please list any medications your child will need to take during the school day:

All daily medications taken during school requires a separate Medication Consent Form signed by the authorized prescriber and parent/guardian.

I give my consent for my child's health care provider and Corporate School Nurse to discuss the information on this form for confidential use in meeting my child's health and educational needs in the educational setting.	Signature of Parent/Guardian	Date
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Part 2 --- Medical Evaluation

Health Care Provider must complete and sign the medical evaluation, physical examination and review immunization record.

Child's Name:

DOB:

Date of Exam:

☐ I have reviewed the health history information provided in Part 1 of this form.

Height: _____

Weight: _____

Eyes:

Vision (Snellen):

Right: _____ / _____

Left: _____ / _____

Ears: Right _____

Left _____

Nose:

Teeth:

Throat:

Heart:

Rate: _____

Blood Pressure

_____ / _____

Lungs:

Note any additional information:

Abdomen:

Orthopedics:

Skin:

General Condition:

History of severe illnesses, injuries or surgeries:

Record of Immunizations:

Please indicate below if your office inputs all immunization information into CHIRP database.

See CHIRP records ☐

Copy of immunization records
is attached (** See below **) ☐

Please indicate if
immunizations are up to
date or on a catch up
schedule:

Up To Date: _____
Catching Up: _____

**** If immunizations are from another State, a copy of records is required at the beginning of the school year. ****

Exemption of Immunizations:

Please indicate (in the box below) if you have medical or religious exemptions to any
required school vaccinations. A separate form will be required to be filled out every
school year and on file in the school clinic.

☐

PHYSICIAN'S RECOMMENDATIONS

I recommend medical attention to the following conditions:

Student is physically fit to participate in physical education?

Yes _____ No _____

Date: _____

Physician's Signature:

Address:

Phone:

PLEASE RETURN THIS FORM TO THE SCHOOL NURSE

Part 3 --- Dental Evaluation

Health Care Provider must complete and sign the Dental Evaluation.

Child's Name:

DOB:

Date of Exam:

Care Needed?

Yes _____ / No _____

Recommendations:

D.D.S.

Address

Phone

PLEASE RETURN TO THE SCHOOL NURSE

----- Detatch and keep for future contact information -----

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