CHILD HEALTH REPORT (55 PA CODE 553270.131, 3280.131 AND 3290.131)

•		(55 PA CODI	- 993270.13.	1, 3280.131	AND 3290.	131)	
CHILD'S NAME: (LAST)	(1)	FIRST)		PARENT/GL	MARDIAM:		
ATE OF BIRTH: HO		OME PHONE:		ADDRESS:			
CHILD CARE PACILITY NAME:	٠			•			
FACILITY PHONE:	OUNTY:		WORK PHO	WORK PHONE:			
1 anthorize the child care staff and my child's health professional to communicate directly if needed to clarify information on this form about my child.							
PARENT'S SIGNATURE:							
DO NOT OMIT ANY INFORMATION This form may be updated by a health professional. Initial and date any new data. The child care facility needs a copy of the form.							
HEALTH HISTORY AND MEDICAL INFORMATION PERTINENT TO ROUTINE CHILD CARE AND DIAGNOSIS/TREATMENT IN EMERGENCY (DESCRIBE, IF ANY): NONE							
DESCRIBE ALL MEDICATION AND ANY SPECIAL DIET THE CHILD RECEIVES AND THE REASON FOR MEDICATION AND SPECIAL DIET. ALL MEDICATIONS A CHILD RECEIVES SHOULD BE DOCUMENTED IN THE EVENT THE CHILD REQUIRES EMERGENCY MEDICAL CARE. ATTACH ADDITIONAL SHEETS IF NECESSARY. IN NOISE							
CHILD'S ALLERGIES (DESCRIBE, IF ANY): D NONE							
LIST ANY HEALTH PROBLEMS OR SPECIAL NEEDS AND RECOMMENDED TREATMENT/SERVICES. ATTACH ADDITIONAL SHEETS IF NECESSARY TO DESCRIBE THE PLAN FOR CARE THAT SHOULD BE FOLLOWED FOR THE CHILD, INCLUDING INDICATION OF SPECIAL TRAINING REQUIRED FOR STAFF, EQUIPMENT AND PROVISION FOR EMERGENCIES. IN NONE							
IN YOUR ASSESSMENT, IS THE CHILD ABLE TO PARTICIPATE IN CHILD CARE AND DOES THE CHILD APPEAR TO BE FREE FROM CONTAGIOUS OR COMMUNICABLE DISEASES? D YES: D NO IF NO, PLEASE EXPLAIN YOUR ANSWER:							
HAS THE CHILD RECEIVED ALL AGE APPROPRIATE SCREENINGS LISTED IN THE ROUTINE PREVENTIVE HEALTH CARE SERVICES CURRENTLY RECOMMENDED BY THE AMERICAN ACADEMY OF PEDIATRICS? (SEE INOTE BELOW:IF:THE RESULTS:OF:VISION, HEARING OR LEAD SCREENINGS WERE ABNORMAL, IF THE SCREENING WAS COMPLETED AND INFORMATION:ABOUT REFERRALS, IMPLICATIONS OR ACTIONS RECOMMENDED. CARE FACILITY.							
SCHEDULE AT <u>WWW.AAP.ORG</u>)	VISION (s	ubjective u	ıntil age 3)	_	·		
O YES O NO	HEARING	(subjective	e until age	4)			
	LEAD						
RECORD DATES OF IMMUNIZATIONS BELOW-OR-ATTACH A-PHOTOCOPY OF THE CHILD'S IMMUNIZATION RECORD							
IMMUNIZATIONS	DATE	DATE	DATE	DATE :	DATE	COMMENTS	
HEP-B							
ROTAVIRUS				Approximate the second			
DTAP/DTP/TD				<u> </u>			
НВ	•					· · · · · · · · · · · · · · · · · · ·	
PNEUMOCOCCAL			J	:			
POLIO	<u> </u>	ļ					
INFLUENZA							
MMR		1					
		-					
VARICELLA						<u> </u>	
HEP-A		 				ļ	
MENINGOCOCCAL		<u> </u>			ļ	1	
OTHER TO THE PROMISE IN			<u> </u>		SICUATURE.	- CAT DIVERSIAN CONTROL ON DEPOSIT AND ADDRESS OF THE CONTROL OF T	
MEDICAL CARE PROVIDER: Penn State Hershey Pediatrics ADDRESS: SIGNATURE OF PHYSICIAN, CRMP ON PHYSICIAN'S, ASSISTANT.							
ADDRESS: Penn State Horsing 4 35 Hope Drive, Suite 102					TITLE:		
Hershey, PA 17033 PHONE:					LICENSE NUMBER: DATE FORM SIGNED:		