

Mount Saint Mary Academy
2291 ELM STREET
Manchester, NH 03104

603-623-3155 FAX: 6219254
E-Mail Principal@mtstmary.org
Web Page: www.mtstmary.org



Good Health

Child Health Form

To be completed by Parent or Guardian

_____ D.O.B. : ___/___/___ Sex:
M F
Last Name First Name M.I. Mo Day Year

Child's Address

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

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

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

B. Any chronic illness that may require medication, particularly observations or precautions in a childcare setting (i.e. recurrent ear infections, seizure disorder, allergies)?

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

D. Pertinent family, social or health characteristics?

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Immunizations For Child Care Agency Attendance

You May Substitute A Copy Of Your Own Immunization Record

Vaccine	Date	Date	Date	Date	Date	Date
DTP/DTaP						
Hib						
DTP-Hib						
Td						
OVP or IPV						
MMR						
Hep-B						
Varicella (Recommended)						
Other						

Communicable Disease History

Recommended Screening And Testing

Disease	Date of Diagnosis	Laboratory Confirmation	Physician		Date	Method	Result
Chickenpox		N/A		TB (High Risk)			
				Vision			
				Hearing			
				Speech			
				Hgb/HCT		N/A	
				Urine		N/A	
				Lead		N/A	

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HEALTH ASSESSMENT

PHYSICAL EXAM:

Length / Height ____ In/Cm %ile _____	Weight ____ Lb/Kg %ile _____	Head Circumference ____ In/Cm %ile _____	Blood Pressure ____ / ____
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Check each Line	Normal	Abnormal	Needs Follow-Up	Not Examined	Check each line	Normal	Abnormal	Needs Follow-up	Not Examined
Skin / Scalp					Chest, Breasts				
Nutrition					Teeth & Gums				
Neurology & Muscular					Glands Inc Thyroid				
Orthopedic & Spine					Nose, Throat, Mouth				
Eye					Heart, Lungs				
Ears					Abdomen				
Speech					Genitalia				

Temperament: ____ Easy-going ____ Average ____ Difficult

Comments:

Assessment of Physical Development:

A. Estimate of level of maturation:

- a. Infancy (0-2 years) Early: ____ Mid: ____ Late: ____
- b. Mid-preschool (2-4 years) Early: ____ Mid: ____ Late: ____
- c. Preschool (4 years) Early: ____ Mid: ____ Late: ____
- d. School-age (6-10 yrs) Early: ____ Mid: ____ Late: ____
- e. Adolescent (11-18 yrs) Early: ____ Mid: ____ Late: ____

B. Estimate of functional capacity:

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

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

D. Recommendations regarding:

- a. Medical needs:
- b. Developmental needs:
- c. Family support:

Print Physician's Name _____ Date of Exam _____

Physician's Signature _____ Date of next Scheduled Exam _____