Parent/Provider fill in this part.

Parents may write immunization dates; health professional should verify and complete all data.

CHILD HEALTH REPORT

(55 PA CODE §§3270.131, 3280.131 AND 3290.131)

CHILD'S NAME: (LAST)	(F	IRST)		PARENT/GL	JARDIAN:	
DATE OF BIRTH:	Н	OME PHONE:	PHONE: ADDRESS:			
CHILD CARE FACILITY NAME:		-				
FACILITY PHONE:	OUNTY:		WORK PHONE:			
☐ I authorize the child care staff and my child	d's health pro	fessional to co	mmunicate di	rectly if need	ed to clarify ir	formation on this form about my child.
PARENT'S SIGNATURE:						
			OT OMIT A			
						hild care facility needs a copy of the form. S/TREATMENT IN EMERGENCY (DESCRIBE, IF ANY):
□ NONE	KITON I EKTI	NEW TO KE	JOHNE CHIE	D CARE AN	DIAGNOSI	DATECTIVE IN EMERGENOT (DESCRIBE, IT ANT).
						DICATION AND SPECIAL DIET. ALL MEDICATIONS A CAL CARE. ATTACH ADDITIONAL SHEETS IF NECESSARY.
CHILD'S ALLERGIES (DESCRIBE, IF ANY)):					
NONE						
						TACH ADDITIONAL SHEETS IF NECESSARY TO ITION OF SPECIAL TRAINING REQUIRED FOR STAFF,
EQUIPMENT AND PROVISION FOR EMERGINATION OF EM		OLLOWEDT	OK THE CHI	ILD, INCLUI	JING INDICA	TION OF SPECIAL TRAINING REQUIRED FOR STAFF,
	BLE TO PAR	TICIPATE IN	CHILD CAR	RE AND DOE	S THE CHIL	D APPEAR TO BE FREE FROM CONTAGIOUS OR
COMMUNICABLE DISEASES? YES NO IF NO, PLEASE EXPL.	AIN YOUR A	ANSWER:				
HAS THE CHILD RECEIVED ALL AGE APPROSCREENINGS LISTED IN THE ROUTINE PREHEALTH CARE SERVICES CURRENTLY RECOBY THE AMERICAN ACADEMY OF PEDIATRI	NOTE BELOW IF THE RESULTS OF VISION, HEARING OR LEAD SCREENINGS WERE ABNORMAL. IF THE SCREENING WAS ABNORMAL, PROVIDE THE DATE THE SCREENING WAS COMPLETED AND INFORMATION ABOUT REFERRALS, IMPLICATIONS OR ACTIONS RECOMMENDED FOR THE CHILD CARE FACILITY.					
SCHEDULE AT <u>WWW.AAP.ORG</u>) U YES U NO		VISION (subjective until age 3)				
		HEARING (subjective until age 4)			e 4)	
		LEAD				
RECORD DATES OF IMMU	JNIZATIO	NS BELOW	OR ATTACI	н а рнотс	COPY OF T	HE CHILD'S IMMUNIZATION RECORD
IMMUNIZATIONS	DATE	DATE	DATE	DATE		
НЕР-В				DAIL	DATE	COMMENTS
ROTAVIRUS				DAIL	DATE	COMMENTS
KOTAVIKOS				DAIL	DATE	COMMENTS
DTAP/DTP/TD				DAIL	DATE	COMMENTS
				DAIL	DATE	COMMENTS
DTAP/DTP/TD				DAIL	DATE	COMMENTS
DTAP/DTP/TD HIB				DAIL	DATE	COMMENTS
DTAP/DTP/TD HIB PNEUMOCOCCAL				DALE	DATE	COMMENTS
DTAP/DTP/TD HIB PNEUMOCOCCAL POLIO				DAIL	DATE	COMMENTS
DTAP/DTP/TD HIB PNEUMOCOCCAL POLIO INFLUENZA				DALE	DATE	COMMENTS
DTAP/DTP/TD HIB PNEUMOCOCCAL POLIO INFLUENZA MMR					DATE	COMMENTS
DTAP/DTP/TD HIB PNEUMOCOCCAL POLIO INFLUENZA MMR VARICELLA				DAIL	DATE	COMMENTS
DTAP/DTP/TD HIB PNEUMOCOCCAL POLIO INFLUENZA MMR VARICELLA HEP-A MENINGOCOCCAL					DATE	COMMENTS
DTAP/DTP/TD HIB PNEUMOCOCCAL POLIO INFLUENZA MMR VARICELLA HEP-A						COMMENTS COMMENTS Provided the second of t
DTAP/DTP/TD HIB PNEUMOCOCCAL POLIO INFLUENZA MMR VARICELLA HEP-A MENINGOCOCCAL OTHER MEDICAL CARE PROVIDER:						
DTAP/DTP/TD HIB PNEUMOCOCCAL POLIO INFLUENZA MMR VARICELLA HEP-A MENINGOCOCCAL OTHER						