St. Paul's Episcopal Nursery School Child Health Assesment Teacher/Class ____________

Parents fill in this part.

Child's Name: (Last)	(First)	Parent/Guardian:
Date of Birth:	Home Phone:	Address:
Child Care Facility Name: St. Paul's Episcpal Nursery School		
Facility Phone: 412-531-2644	County: Allegheny	Work Phone:

To Parents: Submission of this form to the child care provider implies consent for the child care provider to discuss the child's health with the child's clinician.

PA child care providers must document that enrolled children have received age appropriate health services and immunizations that meet the current schedule of the American Academy of Pediatrics 141 Northwest Point Blvd., Elk Grove Village, IL 60007.

Health history and medical information pertinent to routine child care and emergencies (describe, if any): ☐ NONE	Date of most recent well-child exam:
Allergies to food or medicine (describe, if any): ☐ NONE	Do not omit any information. Child care facility needs 2 copies.

Health Care professionals should complete all data and attach copy of Immunization Schedule.

LENGTH/HEIGHT	WEIGHT	HEAD CIRCUMFERENCE (Birth to Age 2)	BLOOD PRESSURE (Beginning at age 3)
______IN/CM % ILE ______	______LB/KG % ILE ______	______IN/CM % ILE ______	______ / ______

PHYSICAL EXAMINATION	☑ = NORMAL	If ABNORMAL - COMMENTS
Head/Ears/Eyes/Nose/Throat		
Teeth		
Cardiorespiratory		
Abdomen/GI		
Genitalia/Breasts		
Extremities/Joints/Back/Chest		
Skin/Lymph Nodes		
Neurologic & Developmental		

IMMUNIZATIONS	DATE	DATE	DATE	DATE	DATE	COMMENTS
DTa/DTP/Td						
POLIO						
HIB						
HEP B						
MMR						
VARICELLA						
PNEUMOCOCCAL						
OTHER						

SCREENING TESTS	DATE TEST DONE	NOTE HERE IF RESULTS ARE PENDING OR ABNORMAL
LEAD		
ANEMIA (HGB/HCT)		
URINALYSIS (UA) (at age 5)		
HEARING (subjective until age 4)		
VISION (subjective until age 3)		
PROFESSIONAL DENTAL EXAM		

Health Problems or Special Needs, Recommended Treatment/Medications/Special Care (attach additional sheets if necessary)

☐ NONE

NEXT APPOINTMENT - MONTH/YEAR:

Medical care Provider:		Signature of Physician or CPNP:	
Address:			
	Phone:	License Number:	Date Form Signed:

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ST. PAUL'S NURSERY SCHOOL
1066 Washington Road
Pittsburgh, PA 15228
(412) 531-2644

Child Health Assessment – Page 2
(to be completed by parent)

Child's Name ______________________________ Teacher/Class ______________________

Health Insurance Plan ____

ID# ____________________________________ Group # __________________________

(**OR** attach copy of insurance card. All information on this form is strictly confidential and will only be released to individuals included on the release form below.)

Child's Dentist ____________________________ Dentist Phone # ______________________

Does child have any special health-care needs for which **medication** could be required during school hours? ____ yes/_____ no. If yes, please complete the **Medication Administration Packet.** This packet can be obtained from the school office.

Does child have any special health-care needs for which **treatment** could be required during school hours? ____ yes/_____ no. If yes, please complete the **Care Plan for Children with Special Health Needs.** This form can be obtained from the school office.

Individuals authorized to have access to health information:

School personnel ______
Medical emergency personnel ______
Others ____

Parent's Signature ______________________________________ Date ____________________