

STATE OF DELAWARE
DEPARTMENT OF SERVICES FOR CHILDREN,
YOUTH AND THEIR FAMILIES
OFFICE OF CHILD CARE LICENSING

Family Child Care
Large Family Child Care Home
Day Care Center

NAME _____

BIRTHDATE _____

CHILD HEALTH APPRAISAL

SECTION A: TO BE COMPLETED BY PARENT BEFORE PHYSICAL EXAMINATION

CHECK IF CHILD HAS PROBLEMS WITH ANY OF THE FOLLOWING: GIVE ADDITIONAL COMMENTS BELOW

- | | | | |
|---|---|--|--|
| <input type="checkbox"/> Allergies
(food, medicine, bee sting, etc.) | <input type="checkbox"/> Frequent Colds | <input type="checkbox"/> Fainting | <input type="checkbox"/> Physical Handicap |
| <input type="checkbox"/> Constipation/Diarrhea | <input type="checkbox"/> Hearing Difficulty | <input type="checkbox"/> Speech Difficulty | <input type="checkbox"/> Behavior Problem |
| | <input type="checkbox"/> Seizures | <input type="checkbox"/> Vision Difficulty | <input type="checkbox"/> Asthma |

Other _____

Comments: _____

ADDITIONAL INFORMATION ABOUT YOUR CHILD (include serious illness, accidents, operations, medications, etc. with dates):

Parent/Guardian's Signature _____ Date _____

SECTION B: TO BE COMPLETED BY EXAMINING PHYSICIAN/PEDIATRIC NURSE PRACTITIONER

CODE: X - Within Normal Limits O - See Remarks Below

____ Scalp, Skin	____ Heart	____ Vision	____ Ear, Nose	____ Lungs
____ Hearing	____ Throat	____ Abdomen	____ Blood Pressure	____ Eyes
____ Genitalia	____ Teeth	____ Extremities	____ Neck, Glands	____ Nervous System
____ Height	____ Weight			

REMARKS AND RECOMMENDATIONS: _____

IS CHILD PROGRESSING NORMALLY FOR AGE GROUP? _____

DTP/Hib 1 / /	DTP/Hib 2 / /	DTP/Hib 3 / /	DTP/Hib 4 / /	DTaP/Hib 4 / /
DTP/DTaP 1/ DT / /	DTP/DTaP 2/ DT / /	DTP/DTaP 3/ DT / /	DTP/DTaP 4/ DT / /	DTP/DTaP 5/ DT / /
Td 1 / /	Td 2 / /	Td 3 / /	/ /	/ /
OPV/IPV 1 / /	OPV/IPV 2 / /	OPV/IPV 3 / /	OPV/IPV 4 / /	TB Screening 12 mo / /
MMR 1 / /	MMR 2 / /	HepB 1 / /	HepB 2 / /	HepB 3 / /
Hib 1 / /	Hib 2 / /	Hib 3 / /	Hib 4 / /	HepB/Hib 1 / /
HepB/Hib 2 / /	HepB/Hib 3 / /	Varacella 1 / /	Varacella 2 / /	Influenza 1 / /
Influenza 2 / /	Pneumococcal Polysaccharide 1 / /	Pneumococcal Polysaccharide 2 / /	Pneumococcal Conjugate 1 / /	Pneumococcal Conjugate 2 / /
Pneumococcal Conjugate 3 / /	Pneumococcal Conjugate 4 / /	Hep A 1 / /	Hep A 2 / /	Lyme Vax 1 / /
Lyme Vax 2 / /	Lyme Vax 3 / /	Other: / /	Lead Screen 12 mo / /	

Examiner's Signature _____ M.D. P.N.P. Date: _____

Printed Name: _____ Telephone: _____