

CHILD'S NAME:  
PHYSICAL EXAM:

(To Be completed by Parent or Guardian)

**HEALTH ASSESSMENT:**

CHILD'S LAST NAME

FIRST NAME

M.I.

DOB: MO /

DAY, YEAR

CHILD'S ADDRESS

GIVE PERMISSION TO OBTAIN/RELEASE MEDICAL  
INFORMATION ON THE ABOVE CHILD.

WE/I

PLEASE RETURN TO: St. Peter's Home , 300 Kelley St. Manchester, NH 03102-3093

NAME OF CHILD CARE PROGRAM

**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 CHILD CARE SETTING (E.G., RECURRENT EAR INFECTIONS, SEIZURE DISORDER, ALLERGIES)?

C. ANY HOSPITALIZATIONS, OPERATIONS, OR SPECIAL TESTS OF WHICH A CHILD CARE PROVIDER SHOULD BE AWARE?

D. PERTINENT FAMILY, SOCIAL OR HEALTH CHARACTERISTICS?

**IMMUNIZATIONS FOR CHILD CARE AGENCY ATTENDANCE  
PARENT MAY SUBSTITUTE A COPY OF CHILD'S IMMUNIZATION RECORD**

VACCINE	DATE	DATE	DATE	DATE	DATE	DATE
DTP/DTAP						
HIB						
DTP-HIB						
TD						
OPV OR IPV						
MMR						
HEP-B						
VARICELLA						
OTHER						

**COMMUNICABLE DISEASE HISTORY**

**RECOMMENDED SCREENING & TESTING OF ATTENDEES**

DISEASE	DATE OF DIAGNOSIS	LABORATORY CONFIRMATION	PHYSICIAN		DATE	METHOD	RESULT:
CHICKENPOX		NOT APPLICABLE		TB (FOR HIGH RISK CHILDREN ONLY)			
OTHER:				VISION			
				NEARING			
				SPEECH			
				HIB/HCT		NOT APPLICABLE	
				URINE		NOT APPLICABLE	
				LEAD		NOT APPLICABLE	

LENGTH/HEIGHT  
 \_\_\_\_\_ IN/CM %ILE \_\_\_\_\_

WEIGHT  
 \_\_\_\_\_ LB/KG %ILE \_\_\_\_\_

HEAD CIRCUMFERENCE  
 \_\_\_\_\_ IN/CM %ILE \_\_\_\_\_

BLOOD PRESSURE  
 \_\_\_\_\_ / \_\_\_\_\_

CHECK ( ) EACH LINE	NORMAL	ABNORMAL -	NEEDS FOLLOW-UP	NOT EXAMINED	CHECK EACH LINE:	NO	L	NEEDS - FOLLOW-UP	NOT EXAMINED
SKIN/SCALP					NOSE, THROAT, MOUTH	_____	_____		
NUTRITION					TEETH & GUMS	_____	_____		
NEUROLOGY & MUSCULAR					GLANDS INC. THYROID	_____	_____		
ORTHOPEDIC & SPINE					CHEST, BREASTS				
EYE					HEART, LUNGS				
EARS					ABDOMEN				
SPEECH					GENITALIA				

**TEMPERAMENT:**  
 COMMENTS:

EASY-GOING

AVERAGE

DIFFICULT

**ALLERGIES:** INCLUDE ALLERGIES TO FOOD, MEDICATION, OR OTHER SUBSTANCES:

**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 YEARS)   | EARLY: _____ | MID: _____ | LATE: _____ |
| E. ADOLESCENT (11-18 YEARS)  | EARLY: _____ | MID: _____ | LATE: _____ |

COMMENTS

**B. ESTIMATE OF FUNCTIONAL CAPACITY:**

	DELAYED FOR DEVELOPMENT PHASE	CONSISTENT WITH DEVELOPMENT-PHASE	ADVANCED FOR DEVELOPMENT PHASE	COMMENTS
GROSS MOTOR:				
FINE MOTOR:				
LANGUAGE SKILLS:				
SOCIAL SKILLS:				
EMOTIONAL:				

PRINT PHYSICIAN'S NAME \_\_\_\_\_ DATE OF EXAM \_\_\_\_\_

PHYSICIAN'S SIGNATURE \_\_\_\_\_ DATE OF NEXT EXAM \_\_\_\_\_