

# Shelby Hills Early Childhood Center

## Early Childhood Health Assessment Record

To Parent or Guardian:

In order to provide the best experience, early childhood providers must understand your child's health needs. This form requests information from you (Part I) which will also be helpful to the health care provider when he/she completes the health evaluation (Part II). **Your child MUST have a health examination including lead & hematocrit screenings, a dental examination, and up to date immunizations to be eligible for entrance into Shelby Hills Early Childhood Center preschool program.**

*Please print*

Name of Child (Last, First, Middle)		Social Security Number	Birth Date	Exam Date
Address (Street)		City	Zip	School District
Parents/Guardians Name			Home Phone Numbers/Cell Phone Numbers	
Early Childhood Program <b>Shelby Hills Early Childhood Center</b>			Program Phone # (937)498-4565 Fax (937)498-0085	

### PART I – To be completed by parent/guardian

**Important: Complete Part I before your child is examined**  
**Take this form with you to the health care provider's office.**

Please check answers to the following questions in columns on the left.  
 (Explain all "YES" answers in the space provided below).

- |     | YES                      | NO                       |  |
|-----|--------------------------|--------------------------|--|
| 1.  | <input type="checkbox"/> | <input type="checkbox"/> | Do you have any concerns about your child's general health, development or behavior?   |
| 2.  | <input type="checkbox"/> | <input type="checkbox"/> | Has your child been diagnosed with any chronic disease? <input type="checkbox"/> asthma <input type="checkbox"/> diabetes <input type="checkbox"/> seizures <input type="checkbox"/> other |
| 3.  | <input type="checkbox"/> | <input type="checkbox"/> | Does your child have any allergies (food, insects, medication, latex, etc.)? <b>Please specify below.</b>  |
| 4.  | <input type="checkbox"/> | <input type="checkbox"/> | Does your child take any medications (daily or occasionally)?  |
| 5.  | <input type="checkbox"/> | <input type="checkbox"/> | Does your child have any problems with vision, hearing or speech (glasses, contacts, ear tubes, hearing aids)?   |
| 6.  | <input type="checkbox"/> | <input type="checkbox"/> | Has your child had any hospitalization, operation, major illness or injury, or significant accident?   |
| 7.  | <input type="checkbox"/> | <input type="checkbox"/> | In the last 12 months, has your child experienced any difficulty with wheezing or excessive night coughing?  |
| 8.  | <input type="checkbox"/> | <input type="checkbox"/> | In the last 12 months, has your child experienced any difficulty with excessive weight loss or weight gain, or excessive thirst or urination?  |
| 9.  | <input type="checkbox"/> | <input type="checkbox"/> | Has your child had a dental examination in the last 12 months?   |
| 10. | <input type="checkbox"/> | <input type="checkbox"/> | Has your child had a vision examination in the last 12 months?   |

Please explain any "YES" answers here. For illness/injuries/etc. include year and/or your child's age at the time.

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I give permission for release of information on this form for confidential use in meeting my child's health and educational needs in the early childhood program.

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Date

**PLEASE RETURN THIS FORM & PART II TO PRESCHOOL OFFICE**

## PART II – Health Evaluation

**To the Health Care Provider:** We are now required that all children enrolled in our program must have the following: yearly physical exam, recent hematocrit, blood lead test, and up to date immunizations (or an exemption letter on file). If you have any questions, please do not hesitate to contact us at Shelby Hills (937) 498-4565. Thank you.

\_\_\_\_\_  
Child's Name

\_\_\_\_\_  
Birth Date

\_\_\_\_\_  
Exam Date

### MEDICAL HISTORY

Chronic Illness: \_\_\_\_\_

Seizures: \_\_\_\_\_

Allergies: \_\_\_\_\_

Medications: \_\_\_\_\_

Significant Historical Information: \_\_\_\_\_

### PHYSICAL EXAM:

	NORMAL	ABNORMAL	COMMENTS
Skin			
Head			
Eyes			
Ears			
Nose			
Teeth			
Neck			
Chest			
Heart			
Abdomen			
Back			
Genitalia			
Extremities			
Other			

### IMMUNIZATION RECORD

Vaccine	1 <sup>st</sup>	2 <sup>nd</sup>	3 <sup>rd</sup>	4 <sup>th</sup>	5 <sup>th</sup>
Polio					
DtaP/DTP/DT/Td					
MMR					
HIB					
Hepatitis B					
Varicella					
Other					
Other					

### SCREENING/TEST RESULTS

SCREENING TEST	RESULT	DATE	COMMENTS
Vision			
Speech/Hearing			
Blood Lead Test			
Hematocrit			
Height			
Weight			
Blood Pressure			
Other			

### Disease History of above

\_\_\_\_\_  
(Specify) (Date) (Confirmed by)

### EXEMPTION:

Religious \_\_\_\_\_ Medical: Permanent \_\_\_\_\_ Temporary \_\_\_\_\_

**PART II – Health Evaluation Continued**

\_\_\_\_\_  
Child's Name

\_\_\_\_\_  
Birth Date

\_\_\_\_\_  
Exam Date

**Specific Findings**

A. General Neurological Examination

Gait \_\_\_\_\_ Station \_\_\_\_\_ Muscle Power \_\_\_\_\_

Muscle Tone \_\_\_\_\_ Reflexes \_\_\_\_\_ Cranial Nerves \_\_\_\_\_

B. Motor abnormalities

Gross Motor Coordination: \_\_\_\_\_

Fine Motor Coordination: \_\_\_\_\_

C. Sensory abnormalities:

**Behavioral Problems (check if observed or reported by informant)**

- Hyperactive       Withdrawn       Short Attention Span  
 Disturbed sleep pattern       Distracted  
 Other (please describe) \_\_\_\_\_

**MEDICAL RECOMMENDATIONS (including restrictions/limitations and any medications prescribed)**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

This is to certify that the above-named child has had a complete physical examination.

\_\_\_\_\_  
Physician Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Address & Phone (or physician stamp)