

**CHILD HEALTH FORM**  
**TO BE COMPLETED BY PARENT OR GUARDIAN:**

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
 CHILD'S LAST NAME FIRST NAME M.I. DOB: MO DAY YEAR

\_\_\_\_\_  
 CHILD'S ADDRESS  
 WE/I \_\_\_\_\_ GIVE PERMISSION TO OBTAIN/RELEASE MEDICAL  
 INFORMATION SIGNATURE OF PARENT/GUARDIAN ON THE ABOVE CHILD.

PLEASE RETURN TO: \_\_\_\_\_  
 Pixie Preschool II Londonderry, NH  
 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			
				HEARING			
				SPEECH			
				HIB/HCT		NOT APPLICABLE	
				URINE		NOT APPLICABLE	
				LEAD		NOT APPLICABLE	

