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

NAME____________________

Family Child Care
Large Family Child Care Home
Day Care Center

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

- ❑ Allergies (food, medicine, bee sting etc.)
- ❑ Constipation/Diarrhea
- ❑ Frequent Colds
- ❑ Hearing Difficulty
- ❑ Seizures
- ❑ Fainting
- ❑ Speech Difficulty
- ❑ Vision Difficulty
- ❑ Physical Handicap
- ❑ Behavior Problem
- ❑ 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 / /	Hep B Hib 1 / /
Hep B Hib 2 / /	Hep B Hib 3 / /	Varicella 1 / /	Varicella 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 Screening 12 mo / /	

Examiner's Signature________________________ ❑ M.D. ❑ P.N.P. Date__________

Printed Name:________________________ Telephone:__________