

Child Health Assessment

St. Ambrose University Children's Campus

Parent / Child Information		
Child's Name (Last)	(First)	Date of Birth
Parent / Guardian	Address: _____ City/State/Zip: _____	Home Phone: _____ Work Phone: _____

Child Care Facility Information		
Facility Name	Phone	County

Length / Height	Weight	Head Circumference	Blood Pressure
____ in / cm ____ % ile	____ lb / kg ____ % ile	____ in / cm ____ % ile	____ / ____ (starting age 3)

Physical Examination	X = Normal	If Abnormal - Comments
Head / Ears/ Eyes / Nose / Throat		
Teeth		
Cardio respiratory		
Abdomen / GI		
Extremities / Joints / Back / Chest		
Skin / Lymph Nodes		

Screening Tests	Date Test Done	Note Here If Results Are Pending Or Abnormal
Lead		
Anemia (HGB/HCT)		
Urinalysis (UA (at age 5)		
Hearing (subjective until age 4)		
Vision (subjective until age 3)		

Specific Medical Information	
Health history and medical information pertinent to routine child care and emergencies (describe, if any): ____ None	
Allergies to food / non food / medicine (describe, if any): ____ None	
Health problems or special needs, recommended treatment / medications / special care ____ None	
(attach additional sheets if necessary)	
Signature of physician _____	Date form signed _____
Address _____ Phone _____	Date physical performed _____

- **To Parents: Submission of this form implies consent for St. Ambrose University Children's Campus to discuss the child's health with the child's clinician.**