250 Sweinhart Rd.,Boyertown, PA 19512 610-369-1507 trinityboyertown.org

Child Health Assessment

Child's Name: _____ Parent/Guardian: _____
DOB: _____ Address: _____
Cell Phone: _____ _____
Alt. Phone: _____ Date of exam: _____

Note: A copy of the EPSDT exam report attached to a copy of the child's immunization record may be substituted for this form.
Please attach a copy of child's immunization record if using this form.

Health history and medical information pertinent to routine child care and emergencies: _____

_____

Allergies to food or medicine: _____

Length/Height: _____ IN/CM %ILE: _____ Weight: _____LBS %ILE: _____
Head Circumference: _____IN/CM %ILE: _____ Blood Pressure: _____/_____

Physical Examination	Normal	Abnormal/Comments
Head/Eyes/Nose/Throat		
Teeth		
Cardiorespiratory		
Abdomen/GI		
Genitalia/Breast		
Extremities/Joints/Back/Chest		
Skin/Lymph Nodes		
Neurologic/Tone		
Developmental (E.G. DDST)		

Screening Tests	Date	Normal	Abnormal/Comments
Lead			
Anemia (HGB/HCT)			
Urinalysis (UA)			
Tuberculosis (TB)			
Hearing			
Vision			

Date of last Dental Examination: _____ Results: _____

Health Problems or Special Needs: _____
Recommended Treatment/Medications/Special Care (Attach additional sheets if necessary):

_____

Medical Care Provider: _____ Phone: _____
Address: _____

_____Signature of Physician or CRNP _____ Date