U.S. DEPARTMENT OF HOMELAND SECURITY U.S. COAST GUARD CG-5484A (Rev. 04-05)	**CHILD DEVELOPMENT SERVICES** CHILD HEALTH FORM

To be completed by a health practitioner before admission to a child care program and renewed annually.

_____ has had a complete history and physical examination at my office on
(Child's name: Last/First/Middle)

_____ . Findings for this child are indicated as follows:
Date

1. Date of most recent tuberculin test _____ . Result: Positive _____ Negative _____

2. The child has the following which may significantly affect his education/care experience:

	YES	NO	COMMENTS
a. Visual problem	_____	_____	_____
b. Hearing problem	_____	_____	_____
c. Speech or language problem	_____	_____	_____
d. Other physical illness or impairment	_____	_____	_____
e. Mental, emotional, behavior problem	_____	_____	_____
f. Developmental delays	_____	_____	_____
g. Allergies	_____	_____	_____

Significant physical findings, comments, and recommendations:

3. YES / NO The child has a health condition, which may require care or emergency action while he is at child care. (Please specify, e.g., seizures, bee sting allergy, diabetes, etc.)

Recommendations:

4. YES / NO The child has or is a known carrier of a communicable disease.

Explain:

5. YES / NO The child is on long term medication. Specify:

6. YES / NO The child requires a modified diet and/or special feeding procedures. Specify:

7. YES / NO The child is in good physical and mental health. Except as noted above, he is free of communicable disease, has no problem that may interfere with his learning, and may participate fully in all activities.

ANSWER THE FOLLOWING QUESTIONS ONLY IF RELEVANT:

8. If child cannot fully participate in all areas of child care program, what areas should be limited or altered to suit this child's needs?

9. YES / NO Does child's physical activity need to be restricted? If YES, explain

10. What specialized treatments, if any, will this child require?

    Instructions for care:

11. Does this child require any supportive equipment? (Braces, crutches, etc.) YES NO

    If YES, please specify type _____

    Special instructions for use _____

12. Additional comments:

SIGNATURE & STAMP REQUIRED

_____

Health Practitioner **(please print)** Phone

_____

Signature of Health Practitioner Date

_____

Address