NAME_____

BIRTHDATE_____

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

Family Child Care
Large Family Child Care Home
Day Care Center

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.)	☐ Frequent Colds	☐ Fainting	☐ Physical Handicap
	☐ Hearing Difficulty	☐ Speech Difficulty	☐ Behavior Problem
☐ Constipation/Diarrhea	☐ Seizures	☐ Vision Difficulty	☐ 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 Polysaccharide1 / /	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 / /	

Please attach copy

Examiner's Signature_____ ☐ M.D. ☐ P.N.P. Date:_____

Printed Name:_____ Telephone:_____

DOC.NO. 37-06-10-01-01-01

Pediatric TB Risk Assessment Questionnaire

Name (last, first):_____ Date form completed:___/___/___

Date of Birth:___/___/___

1. Has your child had any contact with a case of tuberculosis?_____

2. Was any household member, including your child, born in or have they traveled to areas where TB is common (e.g. Africa, Asia, Latin America, and the Carribean)? _____

3. Does your child have regular (e.g. daily) contact with adults at high risk for tuberculosis (i.e., those who are HIV infected, homeless, incarcerated, and/or illicit drug users)? _____

4. Does you child have HIV infection? _____

Any "yes" response is considered a positive risk factor and is an indication for administering a Mantoux tuberculin skin test to the child.

☐ This child has been screened for risk of exposure to tuberculosis. Based upon the results of the TB Risk Assessment Questionnaire, the child was not given a Mantoux tuberculin skin test.

Health Care Provider Comments:

_____

_____

Signautre/Title:_____ Date:_____

The practice of universal Mantoux tuberculin skin testing of school children is no longer advocated by the Centers for Disease Control (CDC), American Thoracic Society (ATS), and the American Academy of Pediatrics (AAP). New recommendations for targeted tuberculin testing of high risk persons or groups have been efined in the official joint statements of the ATS/CDC and have ben endorsed by the Infectious Diseases Society of America (IDSA) and the American Academy of Pediatrics in 1999. Adapted from the Delaware Health and Social Services Division of Public Health Pediatric TB Risk Assessment Questionnaire.