# Child Health Appraisal

**NAME_____________________**  
**YOUTH AND THEIR FAMILIES**  
**OFFICE OF CHILD CARE LICENSING**

**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  
- [ ] Frequent Colds  
- [ ] Fainting  
- [ ] Physical Handicap  
- [ ] Constipation/Diarrhea  
- [ ] Hearing Difficulty  
- [ ] Speech Difficulty  
- [ ] Behavior Problem  
- [ ] 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

<table>
<thead>
<tr>
<th>CODE</th>
<th>X - Within Normal Limits</th>
<th>O - See Remarks Below</th>
</tr>
</thead>
<tbody>
<tr>
<td>___ Scalp, Skin</td>
<td>___ Heart</td>
<td>___ Vision</td>
</tr>
<tr>
<td>___ Ear, Nose</td>
<td>___ Lungs</td>
<td></td>
</tr>
<tr>
<td>___ Hearing</td>
<td>___ Throat</td>
<td>___ Abdomen</td>
</tr>
<tr>
<td>___ Blood Pressure</td>
<td>___ Eyes</td>
<td></td>
</tr>
<tr>
<td>___ Genitalia</td>
<td>___ Teeth</td>
<td>___ Extremities</td>
</tr>
<tr>
<td>___ Neck, Glands</td>
<td>___ Nervous System</td>
<td></td>
</tr>
<tr>
<td>___ Height</td>
<td>___ Weight</td>
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</tbody>
</table>

**REMARKS AND RECOMMENDATIONS:**

**IS CHILD PROGRESSING NORMALLY FOR AGE GROUP?**

**Examiner’s Signature_________________________ Date_________________________**

**Printed Name:_________________________ Telephone:_________________________**

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