CHILD HEALTH ASSESSMENT FORM

This form is to be completed within 6 weeks of a child's start date in the program to show the child is current for routine screening tests/ preventative health services and immunizations according to the schedule recommended by the American Academy of Pediatrics, the Centers of Disease Control and Prevention, and the Academy of Family Practice. Reference: NAEYC Accreditation Criterion 5.A.01

FOR OFFICIAL USE ONLY. This form may contain medical information protected by the Privacy Act of 1974 (see AFI 33-332) and Health Insurance Portability and Accountability Act (HIPPA) (see DoD 6025.18-R) not intended for disclosure outside government channels and exempt from mandatory disclosure under the Freedom of Information Act, 5 U.S.C., 552. Exemption 6 may apply. Title 5, U.S.C. 552a, The Privacy Act of 1974, as amended, which affords individuals the right to privacy in records maintained and used by Federal agencies. NOTE: 5 U.S.C. 552a includes Public Law (PL) 100-503, The Computer Matching and Privacy Act of 1988.

PART A: TO BE COMPLETED BY THE CHILD'S SPONSOR

CHILD'S NAME: Last, First, MI.	**DATE OF BIRTH: MM/DD/YYYY**
SPONSOR'S NAME: Last, First, MI.	**GENDER: (CIRCLE)** **Male or Female**

NOTE: Immunization records are maintained and stored at the Program in the child's portfolio.

Health history and medical information pertinent to routine child care and emergencies (describe, if any): ☐NONE			Allergies/ Intolerance: ☐NONE	
Is the above mentioned child covered by TRICARE for health emergencies?	YES	NO	Insurance Carrier	Policy/ Group #
Does the above mentioned child have health and accident insurance other than TRICARE?	YES	NO		

I give permission for the authorized personnel at the **LOS ANGELES CHILD DEVELOPMENT CENTER** to have access to my child's health assessment information necessary for child care (to include this form).

SPONSOR'S SIGNATURE:	**DATE:**

PART A: TO BE COMPLETED BY THE CHILD'S HEALTH CARE PROVIDER

HEALTH PROBLEMS OR SPECIAL NEEDS, RECOMMENDED TREATMENT/ MEDICATIONS/ SPECIAL CARE: (e.g., Asthma, chronic illness, hearing or vision impairments, feeding needs, neuromuscular conditions, urinary, or other ongoing health problems. Additional specifications regarding allergies/intolerance.) (Attach additional documentation if necessary)

☐**NONE**

HEALTH CARE PROVIDER'S STATEMENT: I have examined the above named child and/or reviewed their records and find that he/she is current for age- appropriate routine screenings, immunizations and medically able to participate in the program.

NAME OF MEDICAL CARE		**SIGNATURE OF MEDICAL CARE PROVIDER:**
ADDRESS:	**PHONE:**	**DATE FORM SIGNED:**