New Hampshire Early Childhood Health Assessment Record FOR USE FROM BIRTH THROUGH GRADE 3

To Parent or Guardian: In order to provide the best experience for your child, early childhood providers and school staff must understand your child's health needs. This form requests information from you (Part I) which also will be helpful to the primary health care provider when he or she completes the health evaluation (Part II).

Part I: FAMILY INFORMATION AND HEALTH HISTORY (to be completed by parent or guardian)

Important: Complete this page BEFORE you give this form to your child's primary care provider.

				Please print							
Nam	e of Cl	hild/S	tudent (Last, First, Middle)	Birth Date	Sex	Primary Care Provide	er				
Addr	ess (St	reet)			Town and ZI	Town and ZIP Code					
Pare	nt/Gบล	ardian	1 (Last, First, Middle)	Home Phone Number		Work/Cell Phone Nu	mber				
Is you	*If your child does not have health insurance, s your child currently enrolled in WIC? Yes / No Does your child have health insurance? Yes / No* call 1–877–464–2447 (Children's Medicaid Unit)										
Pleas	Please check "Yes" or "No" next to each question below. Use this checklist to talk to your child's primary care provider about your answers. Yes No										
1	□ □ Do you have any questions or concerns about your child's health, development, or behavior? If "Yes," be sure to discuss these with your child's primary care provider. You may also contact NH Watch Me Grow at your community's family resource center (for children < 6 years) or your school district (children 3 and older) for information about free screenings.										
2			Do you have any concerns about your child's								
3											
4			Does your child have any ongoing health prol			or seizure disorder)?				
5			Does your child have any allergies (to food, m	nedication, insects, lat	tex, etc.)?						
6											
7			Does your child take any medications (daily o	or occasionally)?							
8	□ □ Does your child have any difficulty with his/her vision, hearing, or speech?										
9		, , , , , , , , , , , , , , , , , , , ,									
10			In the past 12 months, have you been concerned about a change in your child's weight?								
11											
12		☐ In the past 12 months, have you noticed that your child is urinating more frequently?									
13			Has your child ever been hospitalized or had a			•					
Explain any "yes" answers here. Give approximate dates for any hospitalizations, operations, or serious illnesses:											
			PERMISSION TO	O EXCHANGE INFOR	MATION						
			arent/Guardian	authoriz	, authorize and request my child's primary care provider						
to e	xcha	nae ir	nformation about my child's health and developme	ent as pertains to this for	m with the pr	rogram/school listed	below.				
			on may be provided by phone, fax, mail, or in perso								
			nd will be used only for the health and educational								
			ate regulations, it will not be re-disclosed to any otl	•		•	•				
			n will expire in one year unless I choose to cancel my								
			•	•							
Name of Program/School Requesting Information											
Pro	gram	/Scho	ol Mailing Address	Signatur	re of Parent/Gu	ardian	Date				
Pro	gram	/Scho	ol Telephone Number Fax Numbe	er Signatur	re of Witness		Date				











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Part II: PHYSICAL EXAMINATION, SCREENING, AND MEDICAL CONDITIONS

To be completed by the child's primary health care provider³/₄must be a licensed physician, nurse practitioner, or physician's assistant.

Name	of Child	/Student	Date of Assessment			PLEASE ATTACH COPY			
Birth D	Pate		Date of Next Scheduled Assessment			OF IMMUNIZATION RECORD			
u	WT	(must be taken within 6o days for WIC)	lb / kg Body N			lass Index (BMI) (if ≥ 2 years)			
	(must be taken within HT 60 days for WIC)		in / cm ☐ 5–84th % ile		le				
atio	HC (if ≤ 2 years)		in / cm BP (if ≥ 3 yea		Mithin normal range				
Physical Examination	Not Yes HEENT		No Indicated		Please comment on any findings outside of normal range, including timeframe for re-evaluation, if applicable:				
	HEARING	Date performed: / /	PLEASE NOTE: Objective hearing L □Pass R □Pass	Fail Fail	at age 4 years is RE	Method: Solution Method: Method: Method:			
		Was child referred for rescreen of	or further evaluation? Y PLEASE NOTE: Objective vision:	Y N O	it age 3 years is REC	Does child wear a hearing aid? Y N N			
ing	VISION	Date performed: / /	L 20/ R 20/	Both		Method: ☐Snellen ☐ther ☐Tumbling E			
Screening		Was child referred for rescreen of PLEASE NOTE: Hgb of	or further evaluation? Y or HCT values at ages 1 and 2 years,			Does child wear glasses? Y N			
Scr	LABS		and 3-6 years are REQUIRED for Head some some some some some some some some	Start /	DEVELOPMENTAL SCREENING (e.g., ASQ, ASQ:SE, M-CHAT, PEDS)	Date of screening: / / Screening tool(s) used:			
tive		HGB: g/dL HCT:	% Date: /	, 1		Typically developing: Y N Referred			
Preventive		Lead: mcg/d	IL Date: /	1		Gross motor			
Pre		Lead: mcg/d	IL Date: /	1	MENT, SO:SE	Fine motor			
		Lead: mcg/d	IL Date: /	1	ELOPI 4SQ, A	Language/communication 🗆 🗆 🗆			
		Is child at risk for TB?	N 🗆 Y 🗆		DEV (e.g., A	Problem-solving			
		If yes, PPD result: POS /		1	ļ	Social/emotional			
	Chroni	c medical conditions/related surge	eries?Nores Special care pl	an attached*	i i	eds/considerations and medications below (other than			
	Medica	ations or treatments?	□No □fes □Special care pl	an attached*		ecial care plans). Please attach Special Meals rrm, if applicable.			
seqs	Allergi	es/sensitivities?	□No □'es □Special care pl						
pecial Need	Behavi	oral issues/mental health diagnos		Special care plan attached*					
peci	Limitat	tions to physical activity?	;— —						
S	Specia	l equipment needs?	□No □res □Special care pl	an attached*					
	Specia	l dietary requirements?	□No □'es □Special care pl	an attached*					
Name, address, and telephone no. of primary health care provider (please print or use stamp):									
				Signature of Pri	imary Health Care Provider Date				
						*Please attach any special care plans or other information			

May 2012