

Part II — Health Evaluation

To the Health Care Provider: Please complete all sections and sign. Explain any screenings required by age but not conducted.

Child's Name		Birth Date (mm/dd/yy)		Date of History/Physical Exam (mm/dd/yy)	
LENGTH/HEIGHT		WEIGHT		WT FOR HT/BMI	
IN/CM	%ILE	LB/KG	%ILE	%ILE	/
HEAD CIRCUMFERENCE¹				BLOOD PRESSURE²	
IN/CM				%	

Screening/Test Results				Immunization Record							
Screening Test	Result	Date	Abnormal/Comments								
Vision² Test type: _____				Vaccine (Month/Day/Year)							
				Dose 1	Dose 2	Dose 3	Dose 4	Dose 5	Dose 6		
				DTP							
				DTP/Hib							
				DTaP							
				DT/Td							
				OPV							
				IPV							
				MMR							
				Measles							
				Mumps							
				Rubella							
				HIB							
				Hep B							
				Varicella							
				PCV							Pneumococcal conjugate vaccine
Screening/Test Results				Other Vaccines (Specify)							
Has this child received dental care in the last 12 months?⁷ <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A											
* Chronic Disease Assessment:											
Yes No				Date of onset							
<input type="checkbox"/> <input type="checkbox"/> Asthma: <input type="checkbox"/> mild <input type="checkbox"/> moderate <input type="checkbox"/> severe <input type="checkbox"/> exercise induced <input type="checkbox"/> unclassified											
<input type="checkbox"/> <input type="checkbox"/> Diabetes: <input type="checkbox"/> Type I <input type="checkbox"/> Type II											
<input type="checkbox"/> <input type="checkbox"/> Anaphylaxis: <input type="checkbox"/> med. <input type="checkbox"/> food <input type="checkbox"/> insect <input type="checkbox"/> latex											
<input type="checkbox"/> <input type="checkbox"/> Seizures: Type _____											
<input type="checkbox"/> <input type="checkbox"/> Other: Please specify _____											
Minimum requirements: ¹ Up to 2 years; ² annual at 3 years; ³ annual at 4 years; ⁴ as needed; ⁵ 9–12 months; ⁶ each visit through 5 years; ⁷ annual at 2–3 years. Federal requirements (eg, Head Start, WIC) may vary. *Prior to Public School Entry: Same as above and Hgb/hct.											
				Disease Hx of above							
				(Specify) _____ (Date mm/yy) _____ (Confirmed by) _____							
				Exemption							
				Religious _____ Medical: Permanent _____ Temporary _____ Date _____							
				Recertify Date _____ Recertify Date _____ Recertify Date _____							

This child has the following problems which may adversely affect his or her educational experience:

Vision Auditory Speech/Language Physical Dysfunction Emotional/Social Behavior
 The child has a health condition which may require intervention at the program, e.g., seizures, allergies, asthma, anaphylaxis, special diet, long-term medication. *Specify:* _____

- Yes No This child has a medical or emotional illness/disorder that now poses a risk to other children or affects the child's ability to participate safely in the program.
 Yes No Based on this comprehensive history and physical examination, this child has maintained his/her level of wellness.
 The child may fully participate in the program.
 The child may fully participate in the program with the following restrictions/adaptation: (Specify reason and restriction.) _____

I would like to discuss information in this report with the early childhood provider and/or health consultant/coordinator.

Signature of health care provider	MD/DO NP PA	Name (Please type or print.)	Phone number
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Address: _____

<input type="checkbox"/> Yes <input type="checkbox"/> No Is this the child's Medical Home?	Next Appointment (mm/yy): _____	Next Immunization Appointment (mm/yy): _____
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Southington-Cheshire Community YMCA
Flu Vaccine Record

Required yearly between September 1 and December 31

Child's Name _____ DOB _____

Address _____

Town _____ Zip _____

Flu Vaccine Administered on _____ (date)

Signature of Physician _____

Address _____

City/Town _____ Zip _____

Please complete this bottom section if your child has not had the Flu Vaccine this year.

_____ My child has an appointment to receive the Flu Vaccine on the indicated date _____.

_____ My child has a medical contraindication to the immunization and will not be getting the Flu Vaccine.

_____ Immunization is contrary to our family's religious beliefs, my child will not be getting the Flu Vaccine.

Parent Signature _____ Date _____