CHILD DEVELOPMENT CENTER
CHILD HEALTH ASSESSMENT FORM

To be completed within 6 weeks after the child begins the program, and at least annually thereafter, to show the child is current for routine screening tests/preventive health services and immunizations according to the schedule recommended by the American Academy of Pediatrics, the Centers for Disease Control and Prevention, and the Academy of Family Practice.

FOR OFFICIAL USE ONLY. This form may contain personal medical information protected by the Privacy Act of 1974 (see AFI 33-332) and the 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 information is maintained at the Program in child's records

Health history and medical information pertinent to routine child care and emergencies (describe, if any): ☐ None			Allergies: ☐ None	
Is the above mentioned child covered by TRICARE for health emergencies?	Y	N		
Does the above mentioned child have health and accident insurance other than TRICARE?	Y	N	Insurance Carrier	Policy/Group#

I give permission for the authorized personnel at the _____
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 B: 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. (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 PROVIDER:	SIGNATURE OF MEDICAL CARE PROVIDER:	
ADDRESS:	PHONE:	DATE FORM SIGNED: