STATE OF DELAWARE
DEPARTMENT OF SERVICES FOR CHILDREN,
YOUTH AND THEIR FAMILIES
OFFICE OF CHILD CARE LICENSING

NAME __________________________

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 (food, medicine, bee sting etc.)
☐ Constipation/Diarrhea
☐ Frequent Colds
☐ Hearing Difficulty
☐ Seizures
☐ Fainting
☐ Speech Difficulty
☐ Vision Difficulty
☐ Physical Handicap
☐ Behavior Problem
☐ 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

CODE: X - Within Normal Limits O - See Remarks Below

<table>
<thead>
<tr>
<th>Code</th>
<th>Scalp, Skin</th>
<th>Heart</th>
<th>Vision</th>
<th>Ear, Nose</th>
<th>Lungs</th>
<th>Hearing</th>
<th>Throat</th>
<th>Abdomen</th>
<th>Blood Pressure</th>
<th>Eyes</th>
<th>Genitalia</th>
<th>Teeth</th>
<th>Extremities</th>
<th>Neck, Glands</th>
<th>Nervous System</th>
</tr>
</thead>
<tbody>
<tr>
<td>DTP/Hib 1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>DTP/DTaP 1 / DT</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Td 1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>OPV/IPV 1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>TB Screening 12 mo</td>
</tr>
<tr>
<td>MMR 1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hib 1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hep B/Hib 2</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Influenza 2</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pneumococcal Polysaccharide 1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pneumococcal Conjugate 3</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lyme Vax 2</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

REMARKS AND RECOMMENDATIONS: __________________________

IS CHILD PROGRESSING NORMALLY FOR AGE GROUP? __________________________

DTP/Hib 2 / DTP/Hib 3
DTP/Hib 4
DTaP/Hib 4
DTaP/DTaP 2 / DT
DTaP/DTaP 3 / DT
DTaP/DTaP 4 / DT
DTaP/DTaP 5 / DT
OPV/IPV 2
OPV/IPV 3
OPV/IPV 4
TB Screening 12 mo
MMR 2
HepB 1
HepB 2
HepB 3
Hib 2
Hib 3
Hib 4
Hep B/Hib 1
Hep B/Hib 3
Varicella 1
Varicella 2
Influenza 1
Pneumococcal Polysaccharide 2
Pneumococcal Conjugate 1
Pneumococcal Conjugate 2
Pneumococcal Conjugate 4
Hep A 1
Hep A 2
Lyme Vax 1

Examiner’s Signature __________________________ M.D. ☐ P.N.P. ☐ Date: __________

Printed Name: __________________________ Telephone: __________________________

DOC NO. 37-06-10-01-01-01