## Parent/Provider fill in this part.

## CHILD HEALTH REPORT

HIB PNEUMOCOCCAL POLIO INFLUENZA MMR VARICELLA HEP-A MENINGOCOCCAL OTHER MEDICAL CARE PROVIDER: SIGNATURE OF PHYSICIAN, CRNP OR PHYSICIAN'S ASSISTANT			(	SS PA CODE	§§3270.131,	3280.131 A	ND 3290.13	1)	
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COMMUNICABLE DISEASES?  YES ON IF NO, PLEASE EXPLAIN YOUR ANSWER:  HAS THE CHILD RECEIVED ALL AGE APPROPRIATE SCREENINGS LISTED IN THE ROUTINE PREVENTIVE HEALTH CARE SERVICES CURRENTLY RECOMMENDED HE SCREENING WAS ABNORMAL, PROVIDE THE DATE THE SCREENING WAS COMPLETED AND INFORMATION ABOUT REFERRALS, IMPLICATIONS OR ACTIONS RECOMMENDED FOR THE CHILD CARE FACILITY.  VISION (subjective until age 3)  HEARING (subjective until age 4)  LEAD  RECORD DATES OF IMMUNIZATIONS BELOW OR ATTACH A PHOTOCOPY OF THE CHILD'S IMMUNIZATION RECORD  IMMUNIZATIONS  DATE  COMMENTS  HEP-B  ROTAVIRUS  DIAPHOTPITD  HIB  PNEUMOCOCCAL  PNEUMOCOCCAL  MMMR  VARICELLA  HEP-A  MENINGOCOCCAL  OTHER  MEDICAL CARE PROVIDER:  SIGNATURE OF PHYSICIAN, CRNP OR PHYSICIAN'S ASSISTANT		LI NONE							
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SCREENINGS LISTED IN THE ROUTINE PREVENTIVE HEALTH CARE SERVICES CURRENTLY RECOMMENDED BY THE AMERICAN ACADEMY OF PEDIATRICS? (SEE SCHEDULE AT WWW.AARORG)  VES NO  RECORD DATES OF IMMUNIZATIONS BELOW OR ATTACH A PHOTOCOPY OF THE CHILD'S IMMUNIZATION RECORD  IMMUNIZATIONS  DATE  COMMENTS  DATE  COMMENTS  DATE  COMMENTS  DATE  COMMENTS  DATE  COMMENTS  DATE  D									
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TITLE:  PHONE: LICENSE NUMBER: DATE FORM SIGNED:	write	MEDICAL CARE PROVIDER:					SIGNATURE	OF PHYSICIAN, CRNP OR PHYSICIAN'S ASSISTANT	
PHONE:   LICENSE NUMBER: DATE FORM SIGNED:			B				SIGNATURE	OF PHYSICIAN, CRNP OR PHYSICIAN'S ASSISTANT	
	Parents may write		3				TITLE:		