

**STATE OF DELAWARE
DEPARTMENT OF EDUCATION
OFFICE OF CHILD CARE LICENSING (OCCL)**

NAME _____

Family Child Care Home
Large Family Child Care Home
Day Care Center
Youth Camp

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.)	☐ Frequent Colds	☐ Fainting	☐ Physical Handicap
☐ Constipation/Diarrhea	☐ Hearing Difficulty	☐ Speech Difficulty	☐ Behavior Problem
☐ Other _____	☐ Seizures	☐ Vision Difficulty	☐ Asthma
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				
_____ Scalp, Skin	_____ Heart	_____ Vision	_____ Ear, Nose	_____ Lungs
_____ Hearing	_____ Throat	_____ Abdomen	_____ Blood Pressure	_____ Eyes
_____ Genitalia	_____ Teeth	_____ Extremities	_____ Neck, Glands	_____ Nervous System
_____ Height	_____ Weight			
REMARKS AND RECOMMENDATIONS: _____				
IS CHILD PROGRESSING NORMALLY FOR AGE GROUP? _____				
DTP/Hib 1 / /	DTP/Hib 2 / /	DTP/Hib 3 / /	DTP/Hib 4 / /	DTaP/Hib 4 / /
DTP/DTaP 1 / DT / /	DTP/DTaP 2 / DT / /	DTP/DTaP 3 / DT / /	DTP/DTaP 4 / DT / /	DTP/DTaP 5 / DT / /
Td 1 / /	Td 2 / /	Td 3 / /	/ /	/ /
OPV/IPV 1 / /	OPV/IPV 2 / /	OPV/IPV 3 / /	OPV/IPV 4 / /	TB Screening 12 mo / /
MMR 1 / /	MMR 2 / /	HepB 1 / /	HepB 2 / /	HepB 3 / /
Hib 1 / /	Hib 2 / /	Hib 3 / /	Hib 4 / /	Hep B/Hib 1 / /
Hep B/Hib 2 / /	Hep B/Hib 3 / /	Varicella 1 / /	Varicella 2 / /	Influenza 1 / /
Influenza 2 / /	Pneumococcal Polysaccharide 1 / /	Pneumococcal Polysaccharide 2 / /	Pneumococcal Conjugate 1 / /	Pneumococcal Conjugate 2 / /
Pneumococcal Conjugate 3 / /	Pneumococcal Conjugate 4 / /	Hep A 1 / /	Hep A 2 / /	Lyme Vax 1 / /
Lyme Vax 2 / /	Lyme Vax 3 / /	Other: / /	Lead Screening 12 mo / /	Lead Screening 24 mo / /

Examiner's Signature _____ ☐ M.D. ☐ P.N.P. Date: _____

Printed Name: _____ Telephone: _____