ASHTON SCHOOL
Roots & Wings

CHILD HEALTH ASSESSMENT

CHILD'S NAME: _____

PARENT/GUARDIAN: _____

ADDRESS: _____

HOME PHONE: _____

WORK PHONE: _____

DATE OF BIRTH: _____

Health history and medical information pertinent to routine child care and emergencies.

Date of Exam: _____

Allergies to food or medicine:

Length/Height	Weight	Head Circumference	Blood Pressure
_____in/cm %ile_____	_____lb/kg %ile_____	_____in/cm %ile_____	_____/_____

Physical Examination	**Normal**	**Abnormal/Comments**
Head/Ears/Eyes/Nose/Throat		
Teeth		
Cardio respiratory		
Abdomen/GI		
Genitalia/Breasts		
Extremities/Joints/Back/Chest		
Skin/Lymph Nodes		
Neurological/Tone		
Developmental (e.g. DDST)		

Immunizatior Date	**Date**	**Date**	**Date**	**Date**	**Comments**
DTP					
Polio					
HIB					
Hep. B					
Other			**NOTE: Ages and number of boosters may vary when immunization start**		

Screening Tests	**Normal**	**Abnormal Comments**
Lead		
Anemia (HOB/HTC)		
Urinalysis (UA)		
Tuberculosis (TB)		

Date of Last Dentist's Examination:

Recommended Treatment/Medications Special Care (Attach Additional Sheets if necessary)

Doctor's name: _____ Phone: _____