



**CHILD DEVELOPMENT CENTER  
CHILD HEALTH ASSESSMENT FORM**

**This form must be completed and turned in  
BEFORE enrollment into program.**

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 (HIPAA) (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
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SPONSOR'S NAME: Last, First, MI.	GENDER: (circle) Male or Female
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**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):  <input type="checkbox"/> None	Allergies:  <input type="checkbox"/> None
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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:
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**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:
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ADDRESS:	PHONE:	DATE FORM SIGNED:
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