

HEALTH ASSESSMENT

NAME OF SPONSOR & SPOUSE (Last, first, MI)		TELEPHONE (Home)	TELEPHONE (Duty)
NAME OF MEDICAL TREATMENT FACILITY/PHYSICIAN	ADDRESS (Include ZIP code)		TELEPHONE

CHILD HEALTH INFORMATION

NAME OF CHILD	BIRTHDATE	SEX	HGT	WGT
HAS CHILD BEEN UNDER REGULAR SUPERVISION OF A PHYSICIAN (If yes, explain circumstance(s) and current status) YES NO				
HAS CHILD BEEN SCREENED FOR ENROLLMENT IN EXCEPTIONAL FAMILY MEMBER PROGRAM YES NO				
COPY OF IMMUNIZATION RECORD SUBMITTED YES NO				

DISEASES AND ILLNESSES (CHECK YES OR NO)

CHICKEN POX	<input type="checkbox"/> YES	<input type="checkbox"/> NO	RUBELLA	<input type="checkbox"/> YES	<input type="checkbox"/> NO	TEN-DAY MEASLES	<input type="checkbox"/> YES	<input type="checkbox"/> NO
MUMPS	<input type="checkbox"/> YES	<input type="checkbox"/> NO				POLIOMYELITIS	<input type="checkbox"/> YES	<input type="checkbox"/> NO
SCARLET FEVER	<input type="checkbox"/> YES	<input type="checkbox"/> NO				RHEUMATIC FEVER	<input type="checkbox"/> YES	<input type="checkbox"/> NO
OTHER (List)								

CHRONIC ILLNESS AND CONDITIONS (Check Yes or No)

VISION PROBLEMS	<input type="checkbox"/> YES	<input type="checkbox"/> NO	ASTHMA	<input type="checkbox"/> YES	<input type="checkbox"/> NO	DIABETES	<input type="checkbox"/> YES	<input type="checkbox"/> NO
ORTHOPEDIC PROBLEMS	<input type="checkbox"/> YES	<input type="checkbox"/> NO	AUDITORY PROBLEMS	<input type="checkbox"/> YES	<input type="checkbox"/> NO			
SEIZURE DISORDER	<input type="checkbox"/> YES	<input type="checkbox"/> NO						
OTHER (List) <input type="checkbox"/>								

ALLERGIES (List)

COMMENT/INDICATE FREQUENCY

COLDS

EAR ACHES

STOMACH ACHES

HEADACHES

DIARRHEA

CONSTIPATION

BED WETTING

SLEEP DIFFICULTIES

POOR EATING HABITS

TANTRUMS

EXCESSIVE ACTIVITY

DESCRIPTION OF SERIOUS CHRONIC ILLNESS/CONDITIONS

ILLNESS/CONDITIONS	DESCRIPTION

ON-GOING MEDICATION

TYPE	DOSAGE	FREQUENCY	CDP ADMINISTERED

SPECIAL MEDICAL CONSIDERATIONS

DESCRIBE ANY SPECIAL PROGRAM NEEDS, CONSIDERATIONS, OR RESTRICTIONS WHICH THE CHILD REQUIRES, IN ORDER TO PARTICIPATE IN CYTP.

MEDICAL STATEMENT

The above named child has been given a routine medical examination (per age requirements) and is free of infectious or contagious diseases, and is considered to be capable of participating fully in CYTP with the exceptions listed above.

SIGNATURE OF SPONSOR/SPOUSE	DATE
PHYSICIAN'S SIGNATURE & STAMP	DATE