HEALTH ASSESSMENT
(REQUIRED BEFORE ADMISSION)
(TO BE COMPLETED BY NURSE OR DOCTOR)

CHILD'S NAME.		DATE:
DATE OR BIRTH:	HEIGHT:	WEIGHT:
PREVIOUS ILLNESS AND/OR OPERATIONS:		
ALLERGIES:		
SPECIAL DIET AND/OR MEDICATION:		
RESULTS OF MEDICAL EXAM:		
MOUTH:		POSTURE:
TEETH:		HEARING:
VISION:		SKIN:
IMMUNIZATION RECORD:		
I HAVE ON THIS DATE EXAMINED THIS CHILD AND FIND HIM/HER FREE OF ANY COMMUNICABLE DISEASE(S):		
Physician's or Nurse's Signature		Date

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