

# New Hampshire Early Childhood Health Assessment Record

## FOR USE FROM BIRTH THROUGH GRADE 3

*To Parent or Guardian: In order to provide the best experience for your child, early childhood providers and school staff must understand your child's health needs. This form requests information from you (Part I) which also will be helpful to the primary health care provider when he or she completes the health evaluation (Part II).*

### Part I: FAMILY INFORMATION AND HEALTH HISTORY (to be completed by parent or guardian)

**Important:** Complete this page **BEFORE** you give this form to your child's primary care provider.

*Please print*

Name of Child/Student (Last, First, Middle)	Birth Date	Sex	Primary Care Provider
Address (Street)		Town and ZIP Code	
Parent/Guardian (Last, First, Middle)	Home Phone Number	Work/Cell Phone Number	

*\*If your child does not have health insurance, talk to your primary care provider or visit <https://nheasy.nh.gov>*

Is your child currently enrolled in WIC?      Yes / No      Does your child have health insurance?      Yes / No\*

Please check "Yes" or "No" next to each question below. Use this checklist to talk to your child's primary care provider about your answers.

- |  |     |    |  |
|--|-----|----|--|
|  | Yes | No |  |
|--|-----|----|--|
- 1         Do you have any questions or concerns about your child's health, development, or behavior?  
*If "Yes," be sure to discuss these with your child's primary care provider. You may also contact NH Watch Me Grow at your community's family resource center (for children < 6 years) or your school district (children 3 and older) for information about free screenings.*
  - 2         Do you have any concerns about your child's eating or sleeping habits?
  - 3         Has your child had a dental exam in the past 6 months?
  - 4         Does your child have any ongoing health problems (such as asthma, diabetes, or seizure disorder)?
  - 5         Does your child have any allergies (to food, medication, insects, latex, etc.)?
  - 6         Does your child require a special diet while in school or other early childhood program?
  - 7         Does your child take any medications (daily or occasionally)?
  - 8         Does your child have any difficulty with his/her vision, hearing, or speech?
  - 9         In the past 12 months, has your child experienced any difficulty with wheezing or coughing?
  - 10        In the past 12 months, have you been concerned about a change in your child's weight?
  - 11        In the past 12 months, have you noticed any change in your child's appetite or thirst?
  - 12        In the past 12 months, have you noticed that your child is urinating more frequently?
  - 13        Has your child ever been hospitalized or had any operations, procedures, or special tests?

Explain any "yes" answers here. Give approximate dates for any hospitalizations, operations, or serious illnesses:

.....

.....

### PERMISSION TO EXCHANGE INFORMATION

I, Name of Parent/Guardian, authorize and request my child's primary care provider to exchange information about my child's health and development as pertains to this form with the program/school listed below. The information may be provided by phone, fax, mail, or in person. I understand that the disclosed information will be considered confidential and will be used only for the health and educational benefit of my child and family. Except as needed to comply with federal and state regulations, it will not be re-disclosed to any other person, school, or agency without my consent. I understand that this form will expire in one year unless I choose to cancel my permission in writing before that time.

.....  
Name of Program/School Requesting Information

.....  
Program/School Mailing Address

.....  
Signature of Parent/Guardian

.....  
Date

.....  
Program/School Telephone Number

.....  
Fax Number

.....  
Signature of Witness

.....  
Date

Endorsed by the NH Department of Health and Human Services; the NH Department of Education; NH Women, Infants & Children Nutrition Program; Head Start; and the NH Pediatric Society



# New Hampshire Early Childhood Health Assessment Record

## Part II: PHYSICAL EXAMINATION, SCREENING, AND MEDICAL CONDITIONS

To be completed by the child's primary health care provider—must be a licensed physician, nurse practitioner, or physician's assistant.

Name of Child/Student		Date of Assessment		PLEASE ATTACH COPY OF IMMUNIZATION RECORD																																																																																			
Birth Date		Date of Next Scheduled Assessment																																																																																					
Physical Examination	WT <i>(must be taken within 60 days for WIC)</i>	lb / kg		Body Mass Index (BMI) <i>(if ≥ 2 years)</i> <input style="width: 80px;" type="text"/>																																																																																			
	HT <i>(must be taken within 60 days for WIC)</i>	in / cm		<input type="checkbox"/> 5–84th % ile	<input type="checkbox"/> < 5th % ile																																																																																		
	HC <i>(if ≤ 2 years)</i>	in / cm		<input type="checkbox"/> 85–94th % ile	<input type="checkbox"/> ≥ 95th % ile																																																																																		
			BP <i>(if ≥ 3 years)</i> /		<input type="checkbox"/> Within normal range	<input type="checkbox"/> ≥ 95th % ile																																																																																	
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Special Needs	Chronic medical conditions/related surgeries?		<input type="checkbox"/> No <input type="checkbox"/> Yes		List special needs/considerations and medications below (other than in attached special care plans). Please attach Special Meals Prescription Form, if applicable.																																																																																		
	Medications or treatments?		<input type="checkbox"/> No <input type="checkbox"/> Yes																																																																																				
	Allergies/sensitivities?		<input type="checkbox"/> No <input type="checkbox"/> Yes																																																																																				
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	Limitations to physical activity?		<input type="checkbox"/> No <input type="checkbox"/> Yes																																																																																				
	Special equipment needs?		<input type="checkbox"/> No <input type="checkbox"/> Yes																																																																																				
	Special dietary requirements?		<input type="checkbox"/> No <input type="checkbox"/> Yes																																																																																				

Name, address, and telephone no. of primary health care provider (please print or use stamp):

Signature of Primary Health Care Provider \_\_\_\_\_ Date \_\_\_\_\_

\*Please attach any special care plans or other information