Child Residential Licensing- Child Health Examination
55 Pa. § Code 3800.143 (e)

Resident Informantion	Evaluation Information		
Name:	Type (Check One) ☐ Initial ☐ Annual ☐ Status Change	Date Resident Evaluated:	Date Form Completed:
Date of Birth:			

(1) Comprehensive Health and Developmental History:

Height:	Weight:	BMI:	Blood Pressure:

Health and developmental history including physical and behavioral: Please provide details such as diagnoses

☐ Unknown

(2) Unclothed Physical Exam

Was the physical exam unclothed?

☐ Yes ☐ No ☐ Not Needed

(3) Immunizations

Are any immunizations, screening tests or laboratory tests needed?

☐ Yes ☐ No

If Yes, please specify:

(4) Blood lead level assessment (5 years of age or younger)

Was a blood lead level assessment completed?

☐ Yes ☐ No ☐ Not Needed

(5) Sickle Cell Screening

Was a Sickle Cell Screening completed?

☐ Yes ☐ No ☐ Not Needed

(6) Gynecological Exam

Is a gynecological examination, breast exam and a Pap recommended?

☐ Yes ☐ No ☐ Not Needed

(7) Communicable Disease Detection

Is communicable disease detection recommended?

☐ Yes ☐ No

(8) Communicable Disease Precautions

Does the child have a communicable disease?

☐ Yes ☐ No

If yes, please provide the specific precautions to be taken to prevent spread of the disease

(9) Medications

☐ None

OR SEE "MEDICATION ADDENDUM" BELOW

Was an assessment of the child's health maintenance needs and medication regimen completed?

☐ Yes ☐ No

Is there a need for blood work?

☐ Yes ☐ No

If yes, please provide details:

(10) Special Health or Dietary Needs

☐ Yes ☐ No ☐ Not Needed

If yes, please provide details:

(11) Allergies or contraindicated medications

☐ Yes ☐ No

If yes, please provide details:

(12) Medical Information

Is there any information pertinent to diagnosis and treatment in case of emergency?

☐ Yes ☐ No

If yes, please provide details:

(13) Physical/Mental Disabilities

Does the child have any physical or mental disabilities?

☐ Yes ☐ No

If yes, please provide details:

(14) Health Education (including anticipatory guidance)

Was health education or anticipatory guidance provided?

☐ Yes ☐ No

If yes, please provide details:

(15) Recommendations for Follow Up

Is a follow up for physical and behavioral health services, examinations and treatment recommended?

☐ Yes ☐ No

If yes, please provide details:

Medical Professional Information

By signing below, I certify that:

• I am a licensed physician, certified registered nurse practitioner or licensed physician's assistant.

Printed Name:	Signature:
Address of Examing Practitioner:	

(9) Medication Addendum				
Medication Name:	Strength (Example: 100 mg)	Dose (Example: 2 Tablets)	Frequency (Example: 2x / Day)	Purpose (Example: Asthma)