

CHILD HEALTH ASSESSMENT

Child's Name: _____

Date of Birth: _____

Physical Exam	Normal	Abnormal/Comments
Head/Ears/Eyes/Nose/Throat		
Teeth		
Abdomen		
Genitalia/Breasts		
Extremities/Joints/Back/Chest		
Skin/Lymph Nodes		
Neurological/Tone		
Developmental		

Please attach an **IMMUNIZATION RECORD** to this form. It can be in the form of a yellow card or a computer generated form from your doctor's office. It must include an expiration date and a doctor's signature to be valid for the State.

I certify that this child has received the immunizations recorded and is in compliance with the rules set forth by the State of Louisiana, Department of Health and Hospitals, Office of Public Health until the expiration date noted. I have examined this child and found him/her to be in good health.

Date

Signature of Physician or CRNP