

# COMPREHENSIVE HEALTH INVENTORY FORM

CHILD'S PERSONAL RECORD

Child's Name \_\_\_\_\_ Birth Date \_\_\_\_\_  
                     First                                    Middle                                    Last

Name of Parent/Guardian Completing \_\_\_\_\_ Relationship \_\_\_\_\_

Dear Parent/Guardian:

Every child should have medical and dental health supervision from birth to age 18. Even healthy children should see a doctor and dentist at regular intervals. Health check-ups should include physical examination and immunizations which are necessary to keep your child free of communicable disease.

This form requests health information from you (Part I) and from your child's Health Practitioner (Part II). The Part I section you complete will be helpful to the Health Practitioner in his evaluation of your child. A copy of the Florida School Entry Health Exam will be accepted in lieu of Part II.

It is necessary that you provide accurate information for this form.

**HEALTH HISTORY:** *(Please check any of the below that apply)*

- |  |     |                                    |       |                        |       |
|--|-----|------------------------------------|-------|------------------------|-------|
| Chronic Illness  | ( ) | Illness lasting more than one week | ( )   | Hospitalizations       | ( )   |
| Surgery  | ( ) | Missing organs                     | ( )   | Allergy to medications | ( )   |
| Allergies to foods   | ( ) | Allergies to other substances      | ( )   | Chest pain w/ exercise | ( )   |
| Asthma   | ( ) | Uses inhaler                       | Y / N | Allergic to bees       | Y / N |
|  |     |                                    |       | Uses EpiPen            | Y / N |
| Dizziness, fainting, frequent headaches, migraines, convulsions                                | ( ) | Concussion or unconsciousness      | ( )   |                        |       |
| Heat exhaustion, heat stroke or other problems in heat   | ( ) | Glasses or contacts                | ( )   |                        |       |
| Is there a history of broken bones or joint or muscle injury                                   | ( ) | Taking any medications             | ( )   |                        |       |
| Dizziness or fainting with exercise  | ( ) | Heart/blood pressure problems      | ( )   |                        |       |
| Wears dental bridges, braces, or retainers   | ( ) | Hearing loss                       | ( )   |                        |       |
| History of autism, CP or other developmental differences                                       | ( ) | Any eating/nutritional disorders   | ( )   |                        |       |
| History of bulimia, anorexia, depression, severe anxiety or other mental or emotional problems | ( ) |                                    |       |                        |       |
| What is the date of the camper's last tetanus shot _____                                       |     | Under the care of a physician      | ( )   |                        |       |

Are there any significant issues or events in your child's life about which we should know (divorce, death in the family, etc.)?

Insurance Information:

Primary physician's name \_\_\_\_\_ Phone # \_\_\_\_\_

Medical insurance company \_\_\_\_\_ Policy number \_\_\_\_\_

Name of primary insured \_\_\_\_\_

**PART I: CHILD'S INFORMATION**

To be completed by **PARENT/GUARDIAN**

**Important:** Complete part I before the health practitioner examines your child. Take this form with you to the health practitioner.

Please check correct answers to the following questions in columns on the right. Explanation, if needed, can be given in the space provided for "REMARKS".

	YES	NO
1. Are you concerned about your child's general health ( <i>eating, sleeping habits, teeth, skin, menstruation, weight, bowel/bladder, etc.</i> )?	_____	_____
2. Does your child have any eye problems ( <i>difficulty seeing, crossed eyes, frequently reddened or watery eyes</i> )?	_____	_____
Date of last eye examination _____ / _____ / _____ Doctor's Name _____		
Results _____		
Does your child wear glasses?	_____	_____
Contact lenses?	_____	_____
3. Does your child have any ear or hearing problems ( <i>frequent earaches, difficulty hearing, etc.</i> )?	_____	_____
Date of last eye examination _____ / _____ / _____ Doctor's Name _____		
Results _____		
Does your child use a hearing aid?	_____	_____
4. Does your child have any speech problems ( <i>difficulty having speech understood, stammering, delayed speech development, etc.</i> )?	_____	_____
5. Does your child have any allergies? If YES, please state what kind of allergies:	_____	_____
6. Does your child have any other specific illness, disability or other limiting condition? If YES, give details under "Remarks".	_____	_____
(a) Does this condition require any special health care in the child care facility or school?	_____	_____
(b) Has your child received evaluation, which could help the child care provider or teacher in meeting his/her health or education needs? If YES, give details under "Remarks".	_____	_____
(c) Does your child require any adaptive equipment?	_____	_____
7. Do you have concerns about your child's behavior or emotional well-being which the camp director or camp counselors should know about? If YES, give details under "Remarks".	_____	_____

**REMARKS** (*Clarify any "YES" answers*):

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**PARENT'S STATEMENT – ALL MUST SIGN AND DATE BELOW**

I give my permission for the health practitioner to complete part II of this form. I understand it is for confidential use in meeting my child's health and educational needs in day camp, child care or school. *Please fill in, if child is school age:*

I give my permission to \_\_\_\_\_ to release \_\_\_\_\_  
Name of Practitioner Name of Child's

health information to \_\_\_\_\_  
Name of Day Camp

*I attest that information provided on this form is true and accurate to the best of my knowledge and belief.*

\_\_\_\_\_  
*Parent/Guardian Signature*

\_\_\_\_\_  
*Date*

**PART II: MEDICAL INFORMATION**

To be completed by a **HEALTH PRACTITIONER**. A copy of the completed Florida School Entry Health Exam will be accepted in lieu of this form.

Child's Name \_\_\_\_\_

1. Date of this child's most recent tuberculin test: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Result: \_\_\_\_\_ Positive \_\_\_\_\_ Negative

2. This child has the following which may significantly affect his/her child care or educational experience:

			COMMENTS
a. Vision problem	<input type="checkbox"/> YES	<input type="checkbox"/> NO	_____
b. Hearing problem	<input type="checkbox"/> YES	<input type="checkbox"/> NO	_____
c. Speech or language problem	<input type="checkbox"/> YES	<input type="checkbox"/> NO	_____
d. Other physical illness or impairment	<input type="checkbox"/> YES	<input type="checkbox"/> NO	_____
e. Mental, emotional or behavior problems	<input type="checkbox"/> YES	<input type="checkbox"/> NO	_____
f. Developmental delays	<input type="checkbox"/> YES	<input type="checkbox"/> NO	_____
g. Allergies	<input type="checkbox"/> YES	<input type="checkbox"/> NO	_____

Significant physical findings, comments and recommendations: \_\_\_\_\_

3. This child has a health condition which may require care or emergency action while at child care/school. \_\_\_\_\_ YES \_\_\_\_\_ NO

Please specify (e.g., seizures, bee sting allergy, diabetes, etc.): \_\_\_\_\_

Recommendations: \_\_\_\_\_

4. This child has or is a known carrier of a communicable disease which should prevent his/her admission to a child care facility or school.

\_\_\_\_\_ YES \_\_\_\_\_ NO If YES, please specify: \_\_\_\_\_

5. This child requires a modified diet and/or special feeding procedures. \_\_\_\_\_ YES \_\_\_\_\_ NO

If YES, please specify: \_\_\_\_\_

**ANSWER THE FOLLOWING QUESTIONS ONLY IF RELEVANT:**

6. If this child cannot fully participate in all areas of the child care program, what areas should be limited or altered to suit his/her needs?

\_\_\_\_\_

7. Does this child's physical activity need to be restricted? \_\_\_\_\_ YES \_\_\_\_\_ NO

If YES, please specify: \_\_\_\_\_

8. Does this child require any specialized treatment? \_\_\_\_\_ YES \_\_\_\_\_ NO

If YES, please specify: \_\_\_\_\_

9. Does this child require any adaptive equipment (braces, crutches, etc.)? \_\_\_\_\_ YES \_\_\_\_\_ NO

If YES, please specify type: \_\_\_\_\_

Special instructions for use: \_\_\_\_\_

10. Additional comments: \_\_\_\_\_

**HEALTH PRACTITIONER'S STATEMENT**

I conducted a physical examination of the above-named child on \_\_\_\_\_ and find that he/she **IS** / **IS NOT** medically cleared to attend Addison Village Summer Camp. (circle correct response)

\_\_\_\_\_  
Name of Health Practitioner (Please Print) Telephone Number

\_\_\_\_\_  
Signature of Health Practitioner Date

