

**STATE OF DELAWARE  
DEPARTMENT OF SERVICES FOR CHILDREN,  
YOUTH AND THEIR FAMILIES  
OFFICE OF CHILD CARE LICENSING**

Family Child Care  
Large Family Child Care Home  
Day Care Center

NAME \_\_\_\_\_

BIRTHDATE \_\_\_\_\_

**CHILD HEALTH APPRAISAL**

**SECTION A: TO BE COMPLETED BY PARENT BEFORE PHYSICAL EXAMINATION**

CHECK IF CHILD HAS PROBLEMS WITH ANY OF THE FOLLOWING: GIVE ADDITIONAL COMMENTS BELOW

<input type="checkbox"/> Allergies (food, medicine, bee sting etc.)	<input type="checkbox"/> Frequent Colds	<input type="checkbox"/> Fainting	<input type="checkbox"/> Physical Handicap
<input type="checkbox"/> Constipation/Diarrhea	<input type="checkbox"/> Hearing Difficulty	<input type="checkbox"/> Speech Difficulty	<input type="checkbox"/> Behavior Problem
	<input type="checkbox"/> Seizures	<input type="checkbox"/> Vision Difficulty	<input type="checkbox"/> Asthma

Other \_\_\_\_\_

Comments: \_\_\_\_\_

ADDITIONAL INFORMATION ABOUT YOUR CHILD (include serious illness, accidents, operations, medications, etc. with dates):  
\_\_\_\_\_  
\_\_\_\_\_

Parent/Guardian's Signature \_\_\_\_\_ Date \_\_\_\_\_

**SECTION B: TO BE COMPLETED BY EXAMINING PHYSICIAN/PEDIATRIC NURSE PRACTITIONER**

CODE: X - Within Normal Limits O - See Remarks Below

_____ Scalp, Skin	_____ Heart	_____ Vision	_____ Ear, Nose	_____ Lungs
_____ Hearing	_____ Throat	_____ Abdomen	_____ Blood Pressure	_____ Eyes
_____ Genitalia	_____ Teeth	_____ Extremities	_____ Neck, Glands	_____ Nervous System
_____ Height	_____ Weight			

REMARKS AND RECOMMENDATIONS: \_\_\_\_\_  
\_\_\_\_\_

IS CHILD PROGRESSING NORMALLY FOR AGE GROUP? \_\_\_\_\_

DTP/Hib 1 / /	DTP/Hib 2 / /	DTP/Hib 3 / /	DTP/ Hib 4 / /	DTaP/Hib 4 / /
DTP/DTaP 1 / DT / /	DTP/DTaP 2 / DT / /	DTP/DTaP 3 / DT / /	DTP/DTaP 4 / DT / /	DTP/DTaP 5 / DT / /
Td 1 / /	Td 2 / /	Td 3 / /		
OPV/IPV 1 / /	OPV/IPV 2 / /	OPV/IPV 3 / /	OPV/IPV 4 / /	TB Screening 12 mo / /
MMR 1 / /	MMR 2 / /	HepB 1 / /	HepB 2 / /	HepB 3 / /
Hib 1 / /	Hib 2 / /	Hib 3 / /	Hib 4 / /	Hep B/Hib 1 / /
Hep B/Hib 2 / /	Hep B/Hib 3 / /	Varicella 1 / /	Varicella 2 / /	Influenza 1 / /
Influenza 2 / /	Pneumococcal Polysaccharide 1 / /	Pneumococcal Polysaccharide 2 / /	Pneumococcal Conjugate 1 / /	Pneumococcal Conjugate 2 / /
Pneumococcal Conjugate 3 / /	Pneumococcal Conjugate 4 / /	Hep A 1 / /	Hep A 2 / /	Lyme Vax 1 / /
Lyme Vax 2 / /	Lyme Vax 3 / /	Other: / /	Lead Screening 12 mo / /	

Please attach copy

Examiner's Signature \_\_\_\_\_  M.D.  P.N.P. Date: \_\_\_\_\_  
Printed Name: \_\_\_\_\_ Telephone: \_\_\_\_\_

*Pediatric TB Risk Assessment Questionnaire*

Name (last, first): \_\_\_\_\_

Date form completed: \_\_\_/\_\_\_/\_\_\_

Date of Birth: \_\_\_/\_\_\_/\_\_\_

1. Has your child had any contact with a case of tuberculosis? \_\_\_\_\_

2. Was any household member, including your child, born in or have they traveled to areas where TB is common (e.g., Africa, Asia, Latin America, and the Caribbean)? \_\_\_\_\_

3. Does your child have regular (e.g. daily) contact with adults at high risk for tuberculosis (i.e., those who are HIV infected, homeless, incarcerated, and/or illicit drug users)? \_\_\_\_\_

4. Does your child have HIV infection? \_\_\_\_\_

Any "yes" response is considered a positive risk factor and is an indication for administering a Mantoux tuberculin skin test to the child.

This child has been screened for risk of exposure to tuberculosis. Based upon the results of the TB Risk Assessment Questionnaire, the child was not given a Mantoux tuberculin skin test.

Health Care Provider Comments:

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Signature/Title: \_\_\_\_\_

Date: \_\_\_\_\_

The practice of universal Mantoux tuberculin skin testing of school children is no longer advocated by the Centers for Disease Control (CDC), American Thoracic Society (ATS), and the American Academy of Pediatrics (AAP). New recommendations for targeted tuberculin testing of high risk persons or groups have been defined in the official joint statements of the ATS/CDC and have been endorsed by the Infectious Diseases Society of America (IDSA) and the American Academy of Pediatrics in 1999. Adapted from the Delaware Health and Social Services Division of Public Health Pediatric TB Risk Assessment Questionnaire.