Child Health Report

Use of form: Use of this form is mandatory to comply with HFS 45.07(6)(L)3. and HFS 46.07(6)(k)3. It also meets the requirements of DWD 55.08(4). Failure to comply may result in issuance of a noncompliance statement. Personally identifiable information gathered on this form will be used only to verify compliance with licensing rules.

Instructions: Each child under 2 years of age shall have an initial health examination not more than 6 months prior to nor later than 3 months after being admitted to the center and a follow-up health examination at least once every 6 months after admission. Except for a school-aged child, each child 2 years of age or older shall have an initial health examination not more than one year prior to nor later than 3 months after being admitted to a center and a follow-up health examination at least once every 2 years after admission.

Parent or Guardian - Complete this section:

Name - Child

Birthdate (mm/dd/yyyy)

Address - Child (Street, City, State, Zip)

Name - Parent or Guardian

Address - Parent or Guardian (Street, City, State, Zip)

Health Professional - Complete this section:

Instructions for feeding and care of child with special problems, including allergies - Specify:

☐ Wisconsin Department of Children and Families requires that all children sleep in their crib/bed on their backs. While we recognize the importance of this requirement for safety concerns, we also recognize the importance of quality sleep in a child's schedule. The parent/guardian of this child has asked that this requirement be waived in an effort to wean/teach the child to sleep in a crib/bed. This child will benefit wholly from falling asleep in a swing/bouncer etc and be moved to a crib/bed when the child is securely asleep.

Date of most recent blood lead test (Medicaid policy requires testing at around ages 12 months and 24 months or once between the ages of 3 and 5 years if no previous test is documented): (mm/dd/yyyy)

Immunization(s) not to be administered to child due to medical reason(s) - Specify:

Authorization

I certify that I have examined the above child on this date and that he / she is able to participate in child care activities.

Name - MD, PA or HealthCheck Provider (please print): _____

Address - (Street, City, State, Zip): _____

Signature - MD, PA or HealthCheck Provider: _____

Date MM-DD-YY (Required)

Child ID (Required)

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