**DEPARTMENT OF CHILDREN AND FAMILIES** **dcf.wisconsin.gov/**

Division of Early Care and Education

**CHILD HEALTH REPORT – CHILD CARE CENTERS**

**Use of form:** Use of this form is voluntary; however, completion of this form meets the requirements of DCF 202.08(4), DCF 250.07(6)(L)3.,and DCF 251.07(6)(k)3. Failure to comply with these rules may result in issuance of a noncompliance statement. Personal information you provide may be used for secondary purposes [Privacy Law, s.15.04(1)(m), Wisconsin Statutes].

**Instructions:** Each child under 2 years of age shall have an initial health examination not more than 6 months prior to nor later than 3months after being admitted to the center and a follow-up health examination at least once every 6 months thereafter. 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 thereafter. The parent / guardian shall give this form to the physician, physician assistant or HealthCheck provider to be completed, signed and dated. The licensee shall obtain a copy for the child’s record. Note: Children are also required to have on file at the child care center documentation of immunizations; it may be helpful if the parent / guardian were to include a copy of the child’s immunization record when submitting this form to the child care center.

**PARENT OR GUARDIAN – Complete this section.**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Name – Child (Last, First, MI) |  | Birthdate – Child (mm/dd/yyyy) | |  |
|  | |  |  |  |
| Address – Child (Street, City, State, Zip Code) | | | |  |
|  | | |  |  |
| Name – Parent or Guardian (Last, First, MI) | | |  |
|  |  | |  |  |
| Address – Parent or Guardian | (Street, City, State, Zip Code) | |  |

**HEALTH PROFESSIONAL – Complete this section.**

Instructions for feeding and care of child with special problems, including allergies – Specify (attach information as necessary).

|  |  |  |
| --- | --- | --- |
| Yes | No Does the child have a milk allergy? | If “Yes”, identify the recommended milk substitute. |
|  | |  |
| Date of most recent blood lead test: | | (mm/dd/yyyy). Note: Children on Medicaid are required to be tested at |

around ages 12 months and 24 months or once between the ages of 3 and 5 years if no previous test is documented. Lead testing is optional for children who are not on Medicaid.

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 (type or print) | Address (Street, City, State, Zip Code) |
| **SIGNATURE –** MD, PA or HealthCheck Provider | Date of Examination |

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