Memo to: Parents/ Health Care Providers

From: The Children's Center of Pittsburgh
327 Craft Avenue
Pittsburgh, PA 15213
412-641-1990
412-641-1361 FAX

Re: Allergies/ Special Care Plan

If the child referred to on the attached form has allergies or special needs of any kind, we appreciate having as much information as possible so that we can properly care for and plan for him or her. We must especially have the following information:

- Signs, symptoms and/or behavioral changes to watch for
- Modifications in diet, feeding position, napping, etc.
- Medication that the child is taking or would need in an emergency
- **Emergency care plan**
  When to call parents/guardians
  When to call 911
  Measures to take until parents/guardians or medical help arrives
  Special training, such as use of an EpiPen, needed by staff

We appreciate your help with this important responsibility.

CHILD HEALTH REPORT

(55 PA CODE §§3270.131, 3280.131 AND 3290.131)

DATE OF EXAM: _____

Parent/Provider fill in this part.

CHILD'S NAME: (LAST)	(FIRST)	PARENT/GUARDIAN:
DATE OF BIRTH:	HOME PHONE:	ADDRESS:
CHILD CARE FACILITY NAME: The Children's Center of Pittsburgh		
FACILITY PHONE: 412-641-1990	COUNTY: Allegheny	WORK PHONE:

☐ I authorize the child care staff and my child's health professional to communicate directly if needed to clarify information on this form about my child.

PARENT'S SIGNATURE:

DO NOT OMIT ANY INFORMATION

This form may be updated by a health professional. Initial and date any new data. The child care facility needs a copy of the form.

HEALTH HISTORY AND MEDICAL INFORMATION PERTINENT TO ROUTINE CHILD CARE AND DIAGNOSIS/TREATMENT IN EMERGENCY (DESCRIBE, IF ANY):
☐ NONE

DESCRIBE ALL MEDICATION AND ANY SPECIAL DIET THE CHILD RECEIVES AND THE REASON FOR MEDICATION AND SPECIAL DIET. ALL MEDICATIONS A CHILD RECEIVES SHOULD BE DOCUMENTED IN THE EVENT THE CHILD REQUIRES EMERGENCY MEDICAL CARE. ATTACH ADDITIONAL SHEETS IF NECESSARY.
☐ NONE

CHILD'S ALLERGIES (DESCRIBE, IF ANY):
☐ NONE

LIST ANY HEALTH PROBLEMS OR SPECIAL NEEDS AND RECOMMENDED TREATMENT/SERVICES. ATTACH ADDITIONAL SHEETS IF NECESSARY TO DESCRIBE THE PLAN FOR CARE THAT SHOULD BE FOLLOWED FOR THE CHILD, INCLUDING INDICATION OF SPECIAL TRAINING REQUIRED FOR STAFF, EQUIPMENT AND PROVISION FOR EMERGENCIES.
☐ NONE

IN YOUR ASSESSMENT, IS THE CHILD ABLE TO PARTICIPATE IN CHILD CARE AND DOES THE CHILD APPEAR TO BE FREE FROM CONTAGIOUS OR COMMUNICABLE DISEASES?
☐ YES ☐ NO IF NO, PLEASE EXPLAIN YOUR ANSWER:

HAS THE CHILD RECEIVED ALL AGE APPROPRIATE SCREENINGS LISTED IN THE ROUTINE PREVENTIVE HEALTH CARE SERVICES CURRENTLY RECOMMENDED BY THE AMERICAN ACADEMY OF PEDIATRICS? (SEE SCHEDULE AT WWW.AAP.ORG)

☐ YES ☐ NO

NOTE BELOW IF THE RESULTS OF VISION, HEARING OR LEAD SCREENINGS WERE ABNORMAL. IF THE SCREENING WAS ABNORMAL, PROVIDE THE DATE THE SCREENING WAS COMPLETED AND INFORMATION ABOUT REFERRALS, IMPLICATIONS OR ACTIONS RECOMMENDED FOR THE CHILD CARE FACILITY.

VISION (subjective until age 3)	
HEARING (subjective until age 4)	
LEAD	

RECORD DATES OF IMMUNIZATIONS BELOW OR ATTACH A PHOTOCOPY OF THE CHILD'S IMMUNIZATION RECORD

IMMUNIZATIONS	DATE	DATE	DATE	DATE	DATE	COMMENTS
HEP-B						
ROTAVIRUS						
DTAP/DTP/TD						
HIB						
PNEUMOCOCCAL						
POLIO						
INFLUENZA						
MMR						
VARICELLA						
HEP-A						
MENINGOCOCCAL						
OTHER						

MEDICAL CARE PROVIDER:	SIGNATURE OF PHYSICIAN, CRNP OR PHYSICIAN'S ASSISTANT
ADDRESS:	TITLE:
PHONE:	LICENSE NUMBER: DATE FORM SIGNED:

Parents may write immunization dates; health professional should verify and complete all data.

When Do Children and Teens Need Vaccinations?

Age	HepB Hepatitis B	DTaP/Tdap Diphtheria, tetanus, pertussis (whooping cough)	Hib *Haemophilus influenzae* type B	IPV Polio	PCV13 Pneumococcal conjugate	RV Rotavirus	MMR Measles, mumps, rubella	Varicella Chickenpox	HepA Hepatitis A	HPV Human papillomavirus	MCV4 Meningococcal conjugate	Influenza Flu
Birth	✔											
2 months	✔ (1–2 mos)	✔	✔	✔	✔	✔						
4 months	✔[1]	✔	✔	✔	✔	✔						
6 months		✔	✔[1]		✔	✔[1]						✔ (One dose each fall or winter to all people ages 6 mos and older. Some children younger than age 9 years may need 2 doses, ask your child's healthcare provider if your child needs more than 1 dose.)
12 months	✔ (6–18 mos)	✔[2] (15–18 mos)	✔ (12–15 mos)	✔ (6–18 mos)	✔ (12–15 mos)		✔ (12–15 mos)	✔ (12–15 mos)	✔✔ (2 doses given 6 mos apart at age 12–23 mos)			
15 months												
18 months			Catch-up[3]		Catch-up[3]		Catch-up[3]	Catch-up[3]				
19–23 months	Catch-up[3]	Catch-up[3]		Catch-up[3]								
4–6 years		✔		✔			✔	✔				
7–10 years		Catch-up[3]					Catch-up[3]	Catch-up[3]	Catch-up[3]	✔✔✔	✔	
11–12 years		✔ (Tdap)		Catch-up[3]						Catch-up[3]	Catch-up[3]	
13–15 years		Catch-up[3] (Tdap)									✔	
16–18 years												

immunization action coalition

immunize.org

Technical content reviewed by the Centers for Disease Control and Prevention

Saint Paul, Minnesota • 651-647-9009 • www.immunize.org • www.vaccineinformation.org

www.immunize.org/catg.d/p4050.pdf • Item #P4050 (8/14)

FOOTNOTES

1 Your infant may not need this dose depending on the type of vaccine that your health-care provider uses.

2 This dose of DTaP may be given as early as age 12 months if it has been 6 months since the previous dose.

3 If your child's vaccinations are overdue or missing, get your child caught up as soon as possible. If your child has not completed a series of vaccinations on time, he or she will need only the remainder of the vaccinations in the series. There's no need to start over.