CHILD
SCHOOL HEALTH RECORD:
DAYCARE & KG

SCHOOL: _____

CHILD'S NAME: _____

CLASS: _____ **DATE:** _____

THIS CHILD'S INFORMATION WAS 1ST REVIEWED ON: (DATE) _____

2ND REVIEW: _____

3RD REVIEW: _____

4TH REVIEW: _____

5TH REVIEW: _____

PART 1: CHILD PERSONAL AND HEALTH INFORMATION

TO BE FILLED BY PARENTS & TEACHERS AT FIRST ADMISSION AND UPDATED EACH YEAR.
IF ANY INFORMATION CHANGES, ADD THE NEW INFORMATION IN THE RELEVANT BOX AND WRITE THE DATE OF CHANGE.

PERSONAL INFORMATION OF THE CHILD		
First and last name		
Date of birth		**Sex of the child:**
Home address		
Contact person (name, relationship to child)		
Home contact phone number		
HEALTH INFORMATION		
Does the child have any health problems (circle)	Asthma | Diabetes | Sickle cell | Other (specify):	
Does the child have any known learning difficulties or disabilities?	Hearing impairment | Visual impairment | Speech impairment Cognition impairment | Retention challenge | Autism | Dyslexia ADHD (specify type) Other (specify)	
Does the child have any known allergies?		
Does the child take any medication?		

INFORMATION FROM CHILD'S MOTHER AND CHILD HEALTH RECORD BOOK			
DATE:			
IMMUNIZATION STATUS *(All vaccines for age completed, p.51-52)*	COMPLETE	INCOMPLETE	If incomplete, follow up:
VITAMIN A SUPPLEMENTATION *(Every 6 months from 6 months, p.52)*	UP TO DATE	NOT UP TO DATE	If not up to date, follow up:
DEWORMING *(Every 6 months from 2 years, p.52)*	UP TO DATE	NOT UP TO DATE	If not up to date, follow up:
Is the child reaching key milestones for their age? *(p.59)*	YES	NO	If no, follow up:
REGULAR GROWTH ASSESSMENT VISITS *(Every 6 months from 2 to 5 years, p43-44)*	YES	NO	If no, follow up:

DATE:			
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PART 2: ANNUAL HEALTH CHECK

TO BE FILLED BY HEALTH STAFF DURING SCHOOL HEALTH VISIT & SHARED WITH PARENTS

GROWTH MONITORING	**DATE:**	**DATE:**	**DATE:**
Child's age (Y, M)			
Child's weight			
Child's height			
Is the child underweight?	NO / YES	NO / YES	NO / YES
Is the child overweight?	NO / YES	NO / YES	NO / YES
Is the child's growth stunted?	NO / YES	NO / YES	NO / YES
DEVELOPMENTAL MILESTONES			
Is the child reaching milestones for their age? (MCHRB, p.59)	YES /NO	YES /NO	YES /NO
If no, is the child reaching milestones for earlier age? (MCHRB, p.59)	YES /NO	YES /NO	YES /NO
VISION & HEARING			
Vision (Tumble E chart)	Normal | Not normal	Normal | Not normal	Normal | Not normal
Hearing	Normal | Not normal	Normal | Not normal	Normal | Not normal
GENERAL EXAM			
Appearance	Healthy-looking | Ill-looking	Healthy-looking | Ill-looking	Healthy-looking | Ill-looking
Posture	Normal | Not normal	Normal | Not normal	Normal | Not normal
Gait	Normal | Not normal	Normal | Not normal	Normal | Not normal
PHYSICAL EXAM			
HEAD	Normal | Not normal	Normal | Not normal	Normal | Not normal
HAIR	Normal | Not normal	Normal | Not normal	Normal | Not normal
SCALP	Normal | Not normal	Normal | Not normal	Normal | Not normal
FACE	Normal | Not normal	Normal | Not normal	Normal | Not normal
EYES	Normal | Not normal	Normal | Not normal	Normal | Not normal
EARS	Normal | Not normal	Normal | Not normal	Normal | Not normal
NOSE	Normal | Not normal	Normal | Not normal	Normal | Not normal
MOUTH	Normal | Not normal	Normal | Not normal	Normal | Not normal
NECK	Normal | Not normal	Normal | Not normal	Normal | Not normal
CHEST	Normal | Not normal	Normal | Not normal	Normal | Not normal
ABDOMEN	Normal | Not normal	Normal | Not normal	Normal | Not normal
SKIN	Normal | Not normal	Normal | Not normal	Normal | Not normal
NAILS	Normal | Not normal	Normal | Not normal	Normal | Not normal
UPPER LIMBS	Normal | Not normal	Normal | Not normal	Normal | Not normal
LOWER LIMBS	Normal | Not normal	Normal | Not normal	Normal | Not normal
REFERRAL	N|Y If YES, reason:	N|Y If YES, reason:	N|Y If YES, reason:

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UPPER LIMBS	Normal | Not normal	Normal | Not normal	Normal | Not normal
LOWER LIMBS	Normal | Not normal	Normal | Not normal	Normal | Not normal
REFERRAL	N|Y If YES, reason:	N|Y If YES, reason:	N|Y If YES, reason:

PART 3: CHILD HEALTH DURING SCHOOL YEAR

TO BE FILLED BY HEALTH WORKERS AND SHARED WITH TEACHERS

1. NOTE DOWN HEALTH, MOOD OR BEHAVIOR CONCERNS YOU OBSERVE IN THE CHILD. **2. ORGANIZE REFERRAL IF NEED BE.** ***For example:*** • Skin problems, eye problems, hearing problems, speech problems • Communicable illness • Lack of appetite; wetting him or herself • Excessive anger, fears or sadness; keeping away from peers
Date: Concern: Action:
Date: Concern: Action:
Date: Concern: Action:
Date: Concern: Action:
Date: Concern: Action:

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TO BE FILLED BY HEALTH WORKERS AND SHARED WITH TEACHERS

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For example:

- Skin problems, eye problems, hearing problems, speech problems
- Communicable illness
- Lack of appetite; wetting him or herself
- Excessive anger, fears or sadness; keeping away from peers

Date: Concern: Action:
Date: Concern: Action:
Date: Concern: Action:
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