Editable Form Instructions

Electronic:
This form is an Editable PDF and the required fields on the form can be filled in directly by just typing, using the Latest Version of Adobe Acrobat Reader. Also with the Latest Version of Adobe Acrobat Reader, you can sign the form electronically saving you time. You then could Email the entire form to MLEDP for convenience.

For Desktops and Laptops: 

This form is most easily filled out on a desktop or laptop computer, but you can also use a mobile device, such as a smart phone or tablet, but you **MUST** install the **Mobile Version** of Adobe Acrobat Reader on your iOS, Android, or Windows device. ***Go to your App Store to get the Mobile Version of Adobe Acrobat Reader.***

Child Health Report Form (Parent Signature at the top of the form)
You have the following options once the form is completed by you and a doctor:

1. **Scan as a PDF** file the SIGNED Child Health Report Form and **Email** it to MLEDP
   (You could use your smart phone and a PDF scanning app to accomplish this)

2. You can **Print** the form and **Mail** the Child Health Report Form to MLEDP

3. If you have a Child Health Report Form already on file with MLEDP, you don't have to do anything, except √ Check the box on the Final Checklist Section of the Registration Form indicating your Child Health Report form is already on file at MLEDP.

Mail to: MLEDP
250 Mt. Lebanon Blvd., Suite 414
Pittsburgh, PA 15234

Email to: Kids@MLEDP.org

Scroll Down to the Child Health Report Form below

Child Health Report - 1.0

CHILD HEALTH REPORT

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

Medical Provider MUST SIGN This Form

Parent - Provider fill in this part

CHILD'S NAME: FIRST LAST	PARENT/GUARDIAN:
DATE OF BIRTH: HOME PHONE:	PARENT/GUADIAN ADDRESS: STREET - CITY - STATE - ZIP
CHILD CARE FACILITY Mt. Lebanon Extended Day Program	
FACILITY PHONE: 412-343-1661 COUNTY: Allegheny	PARENT/GUARDIAN 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 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.

Medical Provider Signs Above