NAVAJO TECHNICAL UNIVERSITY
CHILD CARE SERVICES

Laureen Becenti, Manager: (505) 387-7375
Mae James, Lead Teacher: (505) 387-7466
Email: lbecenti@navajotech.edu

Child Health Assessment

Patient Information to be completed by Parent/Guardian

Child's Name: (Last)	(First)	(M)	Date of Birth:
Parent/Guardian:			
Mailing Address:	(City)	(State)	(Zip Code)
Telephone:	Mobile:		

Medical Information to be completed by Physician or Certified Registered Nurse Practitioner

Current Medications, Vitamins, Herbal Supplements:	Weight: Height:
Vision Exam: R_____ L_____ Both_____ Corrected: ☐Yes ☐No Refer: ☐Yes ☐ No	
Hearing Screening: ☐ Right ☐ Pass ☐ Refer	☐Left ☐ Pass ☐ Refer
Is immunization up-to-date: ☐Yes ☐ No If no, please describe: _____	
_____	
_____	
Next immunization date(s):	

Dental Information

Dental Provider Name:	
Requires Dental Care: ☐ Yes ☐ No	☐ Does Not Require Dental Care At This Time
Last Dental Appointment:	Next Dental Appointment Date:

Describe all medication and reason for medicine: _____
_____
_____

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Does the child require special diet? □ Yes □ No If yes, please describe _____

_____

_____

	Normal	Abnormal	Description
Eyes/Vision			
Nose/Head/Neck			
Mouth/Throat/Teeth			
Ear			
Skin/Hair/Nails			
Neck			
Heart			
Chest/Lungs			
Abdomen			
Genitourinary			
Extremities			
Spine/Hip/Pelvis			
Neurological			

Child's Allergies (Describe, if any): _____

_____

_____

Assessment/ Referrals/Plan/Follow-up:_____

_____

_____

Medical Care Provider:		Signature of Physician or CRNP
Address:		Title:
Phone:	License Number:	Date: