Harwood Center
711 Jefferson Ave
901-448-6580   Fax 901-448-4734

Early Intervention Health Information Form

It is a State of Tennessee requirement that all children enrolled in Early Intervention or Childcare Services must have a Health Form, ***completed and signed by his/her physician, EACH YEAR****. Without an Annual Health Form, this child will not be able to continue receiving early intervention or childcare services. Please attach an up to date record of immunization also.*

Child's Name: ____________________________Birthdate: ____________ Exam Date: __________________

Parent's or Guardian's Name:
____

Home Address ____
Address City State Zip County

Phone: ____________________ Alternate Phone:__________________________

Allergies Yes No
Medication ___ ___
Food ___ ___
Allergic To: _____________
____
____

Hearing Yes No
Hearing Aids ___ ___
Hearing Normal ___ ___
P.E. Tubes ___ ___
Hearing Test Completed ___ ___
Hearing Test Recommended ___ ___

Dental Yes No
Gum Problems ___ ___
Teeth Problems ___ ___
Describe___________________
____

Nutrition Yes No
Formula ___ ___
Type ______________________
Breast Fed ___ ___
Solids ___ ___
Problems___________________
____

Oral Motor _Yes No
Swallowing Problems ___ ___
Oral Defensiveness ___ ___
Describe_______________________

Vision Yes No
Wears Glasses ___ ___
Follows Light ___ ___
Visually Tracks Objects ___ ___
Strabismus ___ ___
Functional Vision Test Completed ___ ___
Functional Vision Test Recommended ___ ___

Seizures Yes No
(if yes complete seizure form) ___ ___

Heart Defects Yes No
___ ___
Describe_______________________________
____

Lung Problems Yes No
___ ___
Describe_______________________________
____

GI Problems Yes No
___ ___
Describe_______________________________
____

Laboratory Results of any of the following:
Microhematocrit/Hemoglobin: _____Date________

Tuberculin Skin Test/Chest X-Ray:_________ Date______
Positive___ Negative____Too young to test _____

Urinalysis: ______________ Date________
Other: __________________ Date________

Weight: ___________________ Height: ____________________

If exempt from immunization, please give reason:
____

Is this person free from communicable disease? Yes ___________ No____________

_____There were no apparent medical findings, which restrict participation in routine, school activities.

_____The following is a list of activities that SHOULD BE RESTRICTED and length of restriction:
____

____

_____ Contraindications or precautions associated with handling or evaluating this child
____

____

Medications Taken Within Last 6 Months
____
____
____

Surgical Procedures
____
____
____
____

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Known Diagnosis

I hereby certify that I have examined the above named child who has been diagnosed as having:
Primary: ____
Secondary: ____
Tertiary: ____

(Please state name of condition or diagnosis, which could result in developmental delays)

Recommendations for Evaluation/Assessment or Treatment if Child Qualifies

_____ Gross Motor/Physical Therapy
_____ Fine Motor/Occupational Therapy
_____ Speech/Language Therapy
_____ Other: ____

Specify Any Instructions for the Following Special Treatments if Indicated/Ordered

Breathing Treatments:
____

Special Feedings:
____

Monitoring:
____

Oxygen:
____

Tracheotomy:
____

G-Tube/Button:
____

Other:
____

____
Signature of Examining Physician or Health Care Provider

____
Please Print or Type Name of Physician or Health Care provider

____
Date of Examination

____
Address

________________ ________________
Office Phone Fax #

____
City State Zip