# CHILD DEVELOPMENT SERVICES *(CDS)* CHILD HEALTH ASSESSMENT

For use of this form, see AR 608-10; the proponent agency is DCSPER

**DATA REQUIRED BY THE PRIVACY ACT OF 1974**

**AUTHORITY:** Title 10, United States Code, Section 3013.
**PRINCIPAL PURPOSE:** Information is used by DA personnel to: (1) verify child health status and currency of immunization per admission requirements: (2) note special program considerations or restrictions on child participation; (3) execute emergency medical procedures for chronic illnesses/conditions; (4) refer child for enrollment in Exceptional Family Member Program.
**ROUTINE USES:** Information provided may be released IAW the Army's blanket routine uses contained in AR 340-21.
**DISCLOSURE:** Disclosure of requested information is voluntary; however, if information is not provided, individuals may not be able to participate in CDS programs.

| NAME OF SPONSOR *(Last, first, MI)* | TELEPHONE *(Home)* | TELEPHONE *(Duty)* |
|---|---|---|
| | | |

| NAME OF MEDICAL TREATMENT FACILITY/PHYSICIAN | ADDRESS *(Include ZIP Code)* | TELEPHONE |
|---|---|---|
| | | |

CHILD HEALTH INFORMATION *(Sponsor)*

| NAME OF CHILD | BIRTH DATE | SEX |
|---|---|---|
| | | |

HAS CHILD BEEN UNDER REGULAR SUPERVISION OF A PHYSICIAN *(If yes, explain circumstance(s) and current status)*

☐ YES ☐ NO

HAS CHILD BEEN SCREENED FOR ENROLLMENT IN EXCEPTIONAL FAMILY MEMBER PROGRAM ☐ YES ☐ NO

IMMUNIZATION DATES *(List Month and Year)*

| | | | | |
|---|---|---|---|---|
| DPT | | | | |
| TOPV | | | | |
| MMR | | | | |
| TINE | | | | |

DISEASES AND ILLNESSES *(Check Yes, or No)*

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| CHICKEN POX | ☐ YES | ☐ NO | RUBELLA | ☐ YES | ☐ NO | TEN-DAY MEASLES | ☐ YES | ☐ NO |
| MUMPS | ☐ YES | ☐ NO | POLIOMYELITIS | ☐ YES | ☐ NO | RHEUMATIC FEVER | ☐ YES | ☐ NO |
| SCARLET FEVER | ☐ YES | ☐ NO | | | | | | |

OTHER *(List)* _____

CHRONIC ILLNESSES AND CONDITIONS *(Check Yes, or No)*

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| VISION PROBLEMS | ☐ YES | ☐ NO | AUDITORY PROBLEMS | ☐ YES | ☐ NO | | | |
| ORTHOPEDIC PROBLEMS | ☐ YES | ☐ NO | ASTHMA | ☐ YES | ☐ NO | DIABETES | ☐ YES | ☐ NO |
| SEIZURE DISORDER | ☐ YES | ☐ NO | | | | | | |

OTHER *(List)* _____

ALLERGIES *(List)* _____

COMMENTS/INDICATE FREQUENCY

COLDS

EAR ACHES

STOMACH ACHES

HEADACHES

| COMMENT/INDICATE FREQUENCY |
|---|
| DIARRHEA |
| CONSTIPATION |
| BED WETTING |
| SLEEP DIFFICULTIES |
| POOR EATING HABITS |
| TANTRUMS |
| EXCESSIVE ACTIVITY |

DESCRIPTION OF SERIOUS CHRONIC ILLNESS/CONDITIONS *(Medical Staff)*

| ILLNESS/CONDITIONS | EARLY SYMPTOMS | RECOMMENDED CDS PROCEDURES |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

COMMENTS

ON-GOING MEDICATION *(Medical Staff)*

| TYPE | DOSAGE | FREQUENCY | CDS ADMINISTERED |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

MEDICAL STAFF COMMENTS

HEIGHT _____ WEIGHT _____ VISION _____ HEARING _____

**SPECIAL MEDICAL CONSIDERATIONS**

DESCRIBE ANY SPECIAL PROGRAM NEEDS, CONSIDERATIONS, OR RESTRICTIONS WHICH THE CHILD REQUIRES, IN ORDER TO PARTICIPATE IN CDS PROGRAMS

REFERRAL FOR CHILD FIND SCREENING ☐ YES ☐ NO

**MEDICAL STATEMENT**

The above named child has been given a routine medical examination and has been found free of infectious or contagious diseases, and to be capable of participating fully in CDS programs with the exception listed above.

| SIGNATURE OF MEDICAL FACILITY REPRESENTATIVE | DATE |
|---|---|
| SIGNATURE OF SPONSOR | DATE |