The Center for Autism
BETTER OUTCOMES FOR LIFE

CLIENT HEALTH ASSESSMENT

Date: _____

Section 1: To Be Completed By Parent/Guardian

Client's Name (Last)	(First)
Date of Birth	Home Phone
Cell Phone	Work Phone

Parent/Guardian's Name
Address

To Parents: Submission of this form to The Center for Autism implies consent for The Center for Autism to discuss the child's health with the child's clinician.

The Center for Autism must document that enrolled clients have received age appropriate health services and immunizations that meet the current schedule of the American Academy of Pediatrics. This schedule is available at www.aap.org or from The Center for Autism

Section 2: To Be Completed By Physician

Health history and medical information pertinent to routine child care (describe, if any):

☐ **NONE** **Initials:** _____

Medical condition that may require emergency medical attention (describe, if any) COMPLETE ATTACHED MEDICAL CARE ACTION PLAN:

☐ **NONE** **Initials:** _____

Allergies to food or medicine (describe, if any) COMPLETE ATTACHED FOOD OR MEDICINE ALLERGY ACTION PLAN:

☐ **NONE** **Initials:** _____

Current Prescribed Medications:

☐ **NONE** **Initials:** _____

Restrictions (describe, if any):

☐ **NONE** **Initials:** _____

Date of most recent well-child exam:

Length/Height	Weight	Head Circumference	Blood Pressure
____ IN ____ % ILE	____ LB ____ % ILE	____ IN ____ % ILE	____ / ____

Physical Examination	√ = Normal	If Abnormal - Comments
HEAD/EARS/EYES/NOSE/THROAT		
TEETH		
CARDIO-RESPIRATORY		
ABDOMEN/GI		
GENITALIA/BREASTS		
EXTREMITIES/JOINTS/BACK/CHEST		
SKIN/LYMPH NODES		
NUEROLOGIC AND DEVELOPMENTAL		

3905 Ford Road, Suite 6, Philadelphia, PA 19131-2824
Phone: 215.878.3400 • Fax: 215.878.2082 • www.thecenterforautism.org
A non-profit organization

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Client/Patient Name:_____

Screening Tests	Date Test Done	Note Here if Results are Pending or Abnormal
LEAD		
ANEMIA (HGB/HCT)		
URINALYSIS (UA) (at age 5)		
HEARING (subjective until age 4)		
VISION (subjective until age 3)		
PROFESSIONAL DENTAL EXAM		

Immunizations	Date	Date	Date	Date	Date	Comments
DTAP/DTP/TD						
POLIO						
HIB						
HEP B						
MMR						
VARICELLA						
PNEUMOCOCAL						
OTHER						

This child cannot be immunized for: _____
(A note from your doctor must be attached)

Primary Healthcare Provider/Pediatrician:		Signature of Physician:	
Address:			
	Phone:	License Number:	Date Signed:

You may return via fax attention to ___Medical Records_____ at 215-878-2082.
This form must be renewed annually.
Thank you for your prompt response.

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