

For office use only

_____	EHS
_____	HSHB
_____	CB

Well Child Exam

Date of exam: _____

Name: _____ DOB: _____

History

Allergies: _____

Medications: _____

Medical Conditions: _____

WIC Program Recipient: No ___ Yes ___ Last Certification Date: _____

Screenings/Assessments: Please enter dates if done previously.

Measurements Date: _____ Height _____ Weight _____ Head Circ. _____

Blood Pressure Date: _____ results _____/_____

Tuberculosis: Please do not leave blank. Assess the child's personal & environmental risk factors & perform tests as needed. **Head Start does not perform Tuberculosis Skin Tests.**

_____ Low Risk: No testing recommended at this time.

_____ At Risk: Test performed.

Date: _____ Type: _____ Results: _____

Recommendations: _____

Immunizations: Please review record & provide update as appropriate for age.

Immunizations reviewed & up to date for age: Yes ___ No ___

Immunizations given today: _____

Anemia Screen: Please do not leave blank. Lab values must be within past 12 months.

Blood Count Date: _____ Hgb _____ HCT _____

Recommendations: _____

Lead Screening: Please do not leave blank. Record results of previous testing or perform test according to EPSDT Standards (i.e. 12 & 24 months of age; children between 36-72 months must receive a blood lead test if they have not previously been tested). Federal Head Start guidelines require Medicaid recipients to follow the State EPSDT guidelines which are listed above.

Dates: _____ Results: _____

Please complete page 2

Name: _____

Physical Exam/Assessments

	Normal	Abnormal	Referred	Not Evaluated	Comments/Treatment Plan
General Appearance					
Posture, Gait					
Speech					
Head					
Skin					
Eyes External Aspects					
Optic Fundoscopic					
Cover Test					
Ears External, TMs					
Nose, Mouth, Pharynx					
Teeth					
Heart					
Lungs					
Abdomen					
Genitalia					
Bones, Joints, Muscles					
Neurological/Social					
Fine Motor					
Communication Skills					
Cognitive					
Self-help Skills					
Social Skills					
Glands, lymph,thyroid					
Muscular Coordination					
Other					

Flouride varnish applied this visit?	Yes	No	Recommendations:
---	-----	----	------------------

Please circle if concerns for: UNDERWEIGHT OVERWEIGHT (please address concerns/education below)

Plan of Care/Recommendations

<u>Acute or Chronic Conditions</u>	<u>Most Recent Occurrence</u>	<u>Treatment Plan</u>
_____	_____	_____
_____	_____	_____

Comments/Recommendations: _____

Return to Clinic for next Well Child Exam at what age? _____

Provider Signature: _____ Date: _____ Clinic/Agency: _____
--