HEAD START HEALTH EXAM REPORT

CHILD'S NAME: _____ **DATE OF BIRTH:** ____/____/____ **CENTER:** _____

DATE OF EXAM: ____/____/____	**WELL BABY CHECK:** ❑ 2 m ❑ 4 m ❑ 6 m ❑ 9 m ❑ 12 m ❑ 15 m ❑ 18 m ❑ 24 m ❑ 30 m **WELL CHILD CHECK** ❑ 3 year, ❑ 4 year, ❑ 5 year ❑ Other_____ **CHILD'S AGE (Months/Years):** _____ **Next Exam Due on (Date/Age):** _____

Health Screenings			**Assessments** (check if completed during medical exam)	
Height in/cm			**Vision**	R 20/__ L 20/__ Both: 20/__ OR ❑ WNL (< 3yrs) ❑ Has glasses ❑ Visual concerns: Refer_____ ❑ Unable: Rescreen in ___ months
Weight lbs./kg			**Hearing**	R: ❑ Pass ❑ Fail L: ❑Pass ❑Fail ❑ Auditory concerns: Refer_____ ❑ Unable: Rescreen in ___ months OR ❑ WNL (< 3yrs)
BMI %		❑Overweight ❑Obese ❑Underweight	**Nutrition Assessment**	❑ No risk ❑ At Risk: Refer_____ ❑ BMI Counseling Given **Attach a nutrition plan if any*
Blood Pressure (3 years and older)		❑ WNL ❑ At risk	**Dental Screening**	❑ WNL ❑ Fluoride Varnish Applied ❑ Dental Problems_____ ❑Refer to DDS
Head Circumference (0-24 months)	cm		**Developmental Assessment**	❑ Development is within age expectations ❑ Developmental concern(s): _____ ❑ Developmental diagnosis: _____

BLOOD TEST RESULTS-*HCT/HGB blood testing required at 12 months and a risk assessment required thereafter.*
Lead testing required at 12 and 24 months. If not completed at 24 months, please test now.

Anemia Risk Assessment (if **YES** to **#1** or **NO** to **#2,** must perform Hgb/Hct test)			**Hemoglobin/Hematocrit** (12m and as needed later)	**LEAD** (12m & 24m)
	1. Do you ever struggle to put food on the table?	❑Yes (t) ❑No	Test Date: _____	Test Date(s): _____
	2. Does your child's diet include iron-rich foods such as meat, eggs, iron-fortified cereals, or beans?	❑Yes ❑No (t)	Result: _____/_____%	Result(s): _____
			❑ WNL OR Retest in ___months	❑ WNL OR Retest in ___months

HEALTH AND DEVELOPMENTAL HISTORY

Asthma*	❑ Yes ❑ No	Is the child currently taking *any* medication(s)? _____ Does medication need to be administered at school? ❑ Yes ❑ No If **YES**, please prescribe a set of medications to be kept at school
Allergies*: Food, medicine, seasonal, other: _____	❑ Yes ❑ No	Does the child need special diet accommodations? If YES, please describe **AND** complete a *Medical Statement to Request Special Meal and/or Accommodations*:
Anemia	❑ Yes ❑ No	**Developmental concerns:**
Seizures*	❑ Yes ❑ No	**Other concerns** (e.g. neurological, orthopedic, etc.)**:**
If YES to asthma, food allergy, and/or seizures, please complete the appropriate Action Plan.		**Open Referrals** (Date and Agency Referred to**):**

TUBERCULOSIS CLEARANCE – Complete only ONE section

❑ Child has no risk factors for TB and does not require TB skin test. Date risk assessed IF different from date of exam listed above: _____	Tuberculin Skin Test (Mantoux/PPD) Date Read: _____ Induration: _____mm. Impression: ❑Negative ❑Positive	Tuberculin Blood Test (QuantiFERON) Date: _____ Impression: ❑Negative ❑Positive

Chest X-Ray/RX: required with **Positive TB** Skin or Blood Test. CXR Date: _____ Impression: ❑Negative ❑Positive

Name of Health Provider (Print):	**Signature:**	**Date:**	**Name of Health Clinic/Address (Print/Stamp):**

**** PLEASE ATTATCH THE MOST RECENT COPY OF IMMUNIZATION HISTORY****