



# Head Start Physical/Well Child Examination

West Central MN Communities Action, Inc., 411 Industrial Park Blvd, Elbow Lake, MN 56531  
P: (218)685-4486 F: (218)685-6747



Child's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Gender: \_\_\_\_\_

Date: \_\_\_\_\_ Name of Clinic: \_\_\_\_\_

\_\_\_\_\_ Month Visit     3 Year Visit     4 Year Visit     5 Year Visit

Measurements			
Height	Weight	BMI/Weight to Length %	Blood Pressure

Child Health History
Chronic Medical Conditions*:
Allergies*:
Medications*:
Behavioral/Social-Emotional Disorder*:

Physical Examination				
N=Normal	AB=abnormal	N	AB	Comments
1.	General Appearance			
2.	Skin			
3.	Nodes			
4.	Head			
5.	Eyes			
6.	Ears			
7.	Nose			
8.	Mouth			
9.	Neck			
10.	Chest			
11.	CV			
12.	Abd			
13.	Genitourinary			
14.	Musculo-Skeletal			
15.	Neuro			

**Laboratory**  
 Program requirements include verification of a 12 mo. and 24 mo. blood lead screening results. If none available – discuss draw today.

Blood Lead	Record Value	Date
Hgb (9-15 mo. range)	Record Value	Date

**Health Assessment**  
 Child Well     Additional diagnosis (specify)

\*Please include any health accommodations or special care plans needed for classroom or group socializations.

Developmental/Social Emotional Screening			
	N	AB	
Personal/Social			Developmental Screening <input type="checkbox"/> PASS    Score: _____ <input type="checkbox"/> MONITOR    _____/_____ <input type="checkbox"/> REFER
Cognitive			Specify tool: ASQ-3    PEDS Other: _____
Speech/Language			Social-Emotional Screening <input type="checkbox"/> PASS    Score: _____ <input type="checkbox"/> MONITOR    _____/_____ <input type="checkbox"/> REFER
Fine Motor			Specify tool: ASQ-SE 2 Other: _____
Gross Motor			
Comments:			

Hearing Screening				
	500 Hz, 25 dB	1000 Hz, 20 dB	2000 Hz, 20 dB	4000 Hz, 20 dB
Right ear	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
Left ear	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
<input type="checkbox"/> PASS <input type="checkbox"/> RESCREEN _____ MO. <input type="checkbox"/> REFER				
Comments:				

**Vision Screening**  
 Right eye: 10/ \_\_\_\_\_    Left eye: 10/ \_\_\_\_\_  
 Wearing corrective lenses

<input type="checkbox"/> PASS	<input type="checkbox"/> RESCREEN _____ MO.	<input type="checkbox"/> REFER
Comments:		

**Follow-Up/Referrals**

Health Care Provider Signature: \_\_\_\_\_ Date: \_\_\_\_\_