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		
Cognitive		
Speech/Language		
Fine Motor		
Gross Motor		

Developmental Screening
☐ PASS Score:
☐ MONITOR _____/_____
☐ REFER
Specify tool: **ASQ-3** **PEDS**
Other:_____

Social-Emotional Screening
☐ PASS Score:
☐ MONITOR _____/_____
☐ REFER
Specify tool: **ASQ-SE 2**
Other:_____

Comments:

Hearing Screening

	500 Hz, 25 dB	1000 Hz, 20 dB	2000 Hz, 20 dB	4000 Hz, 20 dB
Right ear	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No
Left ear	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No

☐ PASS ☐ RESCREEN _____MO. ☐ REFER

Comments:

Vision Screening

Right eye: 10/ ____ **Left eye: 10/** ____

☐ **Wearing corrective lenses**

☐ PASS	☐ RESCREEN _____MO.	☐ REFER

Comments:

Follow-Up/Referrals

Health Care Provider Signature:_____ **Date:**_____