

Head Start Well Child Examination



This Institution is an Equal Opportunity Provider

Patient Information

<input type="checkbox"/> Month <input type="checkbox"/> 2 Year <input type="checkbox"/> 3 Year <input type="checkbox"/> 4 Year <input type="checkbox"/> 5 Year			
Child's Name	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth	

Measurement

Date of exam	Height	Weight	Body Mass Index	Blood Pressure	Pulse
	%	%	%		

Child Health History

Chronic Medical Conditions:
Allergies:
Medications:
Behavioral/Mental Health Disorder:

Physical Examination

N=Normal AB=abnormal		N	Ab	Document abnormal by number:
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			

Developmental/S-E/Mental Health

	N	Ab	Developmental Screening Tool used? <input type="checkbox"/> No <input type="checkbox"/> Yes
Personal/Social			
Cognitive			Name of tool:
Speech/language			Social-emotional Screening Tool Used? <input type="checkbox"/> No <input type="checkbox"/> Yes
Fine Motor			
Gross Motor			Name of tool:

Concerns:

Hearing Screening	Vision Screening
Screened using pure tone audiometer or OAE? <input type="checkbox"/> No <input type="checkbox"/> Yes, results are: <input type="checkbox"/> Pass <input type="checkbox"/> Rescreen in _____ <input type="checkbox"/> Refer	Visual Acuity screened using an LEA/HOTV chart or screening Machine? <input type="checkbox"/> No <input type="checkbox"/> Yes, results are: <input type="checkbox"/> Pass <input type="checkbox"/> Rescreen in _____ <input type="checkbox"/> Refer
Concerns:	Concerns:

Laboratory (Lead)

Require verification of a prior blood lead screening result. If none available – draw today.

Lead	Record Value	Date
Hgb/Hct (if ordered)		

Immunizations

MN Law requires children enrolling in an Early Childhood Program receive a minimum of:
 3-Hep B; 4-DTaP; 3-Polio; 1-MMR; 1-Hib; 1-Varicella; 2-Hep A

Please check the box that applies

Child has completed immunizations required by MN law.	
Behind on immunization schedule. Must receive all required immunizations within 18 months of initial enrollment. Plan to receive them is: (<i>imms. & dates?</i>)	
Child has a medical contraindication or HX of disease with laboratory evidence of adequate immunity that exempts them from the immunization(s) listed below.	
Varicella: Disease was medically diagnoses or adequately described to provider that varicella infection occurred in: _____ (year)	
Parent conscientiously opposed to immunization(s). (HS will inform parent of additional paperwork requirements)	

Immunizations ordered/given today:

DTaP
 Varicella
 IPV/OPV
 Hep A
 Hib
 Hep B
 MMR

Assessment

Child Well
 Additional diagnosis (specify) _____

Follow-up and Referrals

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