EARLY HEAD START/HEAD START WELL CHILD EXAM

Elkhart and St. Joseph Counties Head Start Consortium, 245 N. Lombardy Dr., Door 1, South Bend, IN 46619
Phone: 574-393-5864 Fax: 574-283-8108

CHILD'S NAME: _____ DATE OF BIRTH: _____/_____/_____

Exam, please circle one: 1 Month 2 Months 4 Months 6 Months 9 Months 12 Months 15 Months 18 Months 24 Months Annual

* Height	* Weight	* Head Circumference (Under age 3)	* Blood Pressure (3 years old and older)

* Tests Required per Early Head Start/Head Start State and Federal Guidelines*:

***HGB or HCT: _____SICKLE CELL; (results from newborn screen under age 3) Circle One: Absent/Present/Trait (give results if previously tested)**

***TB TEST: (Perform if determined at risk) Date Given: _____MPD: _____ Not At Risk_____**

***LEAD: (Perform if not previously tested.) (If Previously Tested.)**

Date Given: _____ Lead Level: _____ Date Tested:_____ Lead Level Result:_____

Is there any significant Medical History? (Include any Medications, Etc.)

Does this child have Asthma? _____YES _____ NO If yes is medication required at school? _____YES _____NO

Does this child have a history of SEIZURES? _____YES _____NO If yes is medication required at school? _____YES _____NO

Does this child have any known FOOD ALLERGIES? ____YES ____ NO What is the food Allergy? _____

If FOOD ALLERGIES exist, please write an alternative or substitution: _____

Does this child need an EPI-PEN? _____YES _____NO If yes, for what? _____

Does this child have any restrictions from regular school activities ____YES ____ NO?

If yes, for what? _____

***What powdered Gerber formula do you recommend for infant feeding?* _____**

***If Gerber is not recommended what powdered formula is recommended?* _____**

Category	Normal
Appearance	
Head	
Nose	
Mouth	
Teeth	
Heart	
Lungs	
Abdomen	
Genitalia/Breasts	
Extremities/Back/Chest	
Neurological	
Skin/Lymph Nodes	
Ears/Hearing	
Eyes/Vision	

Further notes (and/or) medication prescriptions for school: _____

_____

_____

_____

Facility/Provider: _____ (PLEASE STAMP)

Dr. Signature: _____

Dr. Phone Number: _____

Date of Exam: _____

***Circle One:**

***Hearing**	**Pass**	**Fail**	
***Vision**	**Pass: Left ____/____ Right ____/____**	**Fail: Left ____/____ Right ____/____**	**Glasses: Y / N**

IMMUNIZATION DATES

Is child up-to-date on immunization Y____ N____. Please attach *printed* up-to-date and current immunization record

For HIB Please Circle: HbOC/PRP-T or PRP-OMP/Merck