

## 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

| Exam, please circle one:    1.Months   2. Months   18 Months   24 Months   26 Months   27 Months   28 | CHILD'S NAME:  |              |              | DATE OF BIRTH:/   |           |        |              |                     |           |  |
|---|--|--------------|--------------|---|-----------|--------|--------------|---------------------|-----------|--|
| * Tests Required per Early Head Start/Head Start State and Federal Guidelines*:  * 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)  * TESTS: (Perform if determined at risk) Date Given: MPD: Not At Risk  * LEAD: (Perform if one 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 any known FOOD ALLERGIES? 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?  | Exam, ple  | ase circle o | one: 1 Montl | h 2 Months  | 4 Mo      | nths 6 | Months 9 M   | <mark>lonths</mark> |           |  |
| * 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.)  *IB TEST: (Perform if determined at risk) Date Given: MPP: Not At Risk  *LEAD: (Perform if not 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 an 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?   Further notes (and/or) medication prescriptions for school:  Appearance  Head  Nose  Mouth  Teetth  Head  Dr. Signature:  Dr. Phone Number:  Date of Exam:  Dr. Phone Number:  Date of Exam:  East-Hearing  Eyes/Vision  *Circle One.**  *Glasses: Y/N  |  |              |              |   |           |        |              | Annual              |           |  |
| **HGB or HCT:SICKLE CELL; (results from newborn screen under age 3) Circle One: Absent/Present/Trait  |  |              | * Height     | * Weig  | ht        |        |              |                     |           |  |
| **HGB or HCT:SICKLE CELL; (results from newborn screen under age 3) Circle One: Absent/Present/Trait  | * 7  | Γests Re     | auired per E | Carly Head  | Start/F   | <br>   | rt State and | l<br>d Federal Gui  | delines*: |  |
| (give results if previously tested)  **TB TEST: (Perform if determined at risk) Date Given: MPP: Not At Risk  **LEAD: (Perform if not 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 an 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?  **What powdered Gerber formula do you recommend for infant feeding? 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 Heart Lungs   |  |              |              |   |           |        |              |                     |           |  |
| Stead   Continue   C  |  |              |              |   |           |        |              |                     |           |  |
| Date Given:   Lead Level:   Date Tested:   Lead Level Result:   |  |              |              |   |           |        |              |                     |           |  |
| Date Given:   Lead Level:   Date Tested:   Lead Level Result:   |  |              |              |   |           |        |              |                     |           |  |
| Is there any significant Medical History? (Include any Medications, Etc.)  Does this child have Asthma?YESNO  |  |              |              |   |           |        |              |                     |           |  |
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| 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 Facility/Provider: (PLEASE STAMP) Abdomen Genitalia/Breasts Extremities/Back/Chest Dr. Phone Number: Neurological Skin/Lymph Nodes Ears/Hearing Ezys/Vision  *Circle One:  Hearing Pass Fail  Vision Pass: Left / Right / Right / Right / Glasses: Y/N  | is there any significant frictical rustory: (include any frictications, Etc.)                  |              |              |   |           |        |              |                     |           |  |
| Does this child have any known FOOD ALLERGIES?YES NO What is the food Allergy?  | Does this child have Asthma?YESNO  |              |              |   |           |        |              |                     |           |  |
| If FOOD ALLERGIES exist, please write an alternative or substitution:  Does this child need an EPI-PEN? YESNO If yes, for what?   | Does this child have a history of SEIZURES?YESNO If yes is medication required at school?YESNO |              |              |   |           |        |              |                     |           |  |
| If FOOD ALLERGIES exist, please write an alternative or substitution:  Does this child need an EPI-PEN? YESNO If yes, for what?   | Does this child have any known FOOD ALLERGIES?YESNO What is the food Allergy?                  |              |              |   |           |        |              |                     |           |  |
| Does this child have any restrictions from regular school activitiesYESNO?  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  *Circle One:  *Hearing Pass Fail Left / Right / Glasses: Y/N   | If FOOD ALLERGIES exist, please write an alternative or substitution:                          |              |              |   |           |        |              |                     |           |  |
| *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 Dr. Signature: Extremities/Back/Chest Nourological Skin/Lymph Nodes Ears/Hearing Eyes/Vision  **Circle One:  *Hearing Pass Fail  *Vision  About Further notes (and/or) medication prescriptions for school:  | Does this child need an EPI-PEN?YESNO If yes, for what?  |              |              |   |           |        |              |                     |           |  |
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| Category Normal Appearance Head Nose Mouth Teeth Heart Lungs Abdomen Genitalia/Breasts Extremities/Back/Chest Neurological Skin/Lymph Nodes Ears/Hearing Eyes/Vision  Pass: Left / Right / Right / Right / Glasses: Y/N  Further notes (and/or) medication prescriptions for school:  Further notes (and/or) medication prescriptions for school: | yy   |              |              |   |           |        |              |                     |           |  |
| Category   Normal   Appearance   Head   | *What powdered Gerber formula do you recommend for infant feeding?                             |              |              |   |           |        |              |                     |           |  |
| Appearance  | If Gerber is not recommended what powdered formula is recommended?                             |              |              |   |           |        |              |                     |           |  |
| Head  | Category   |              | Normal       | Further notes (and/or) medication prescriptions for school: |           |        |              |                     |           |  |
| Mouth   |  |              |              |   |           |        |              |                     |           |  |
| Mouth   | Head   |              |              |   |           |        |              |                     |           |  |
| Teeth   | Nose   |              |              |   |           |        |              |                     |           |  |
| Heart   | Mouth  |              |              |   |           |        |              |                     |           |  |
| Facility/Provider:  | Teeth  |              |              |   |           |        |              |                     |           |  |
| Abdomen   | Heart  |              |              |   |           |        |              |                     |           |  |
| Dr. Signature:  | Lungs  |              |              | Facility/Provider: (PLEASE STAMP)                           |           |        |              |                     |           |  |
| Extremities/Back/Chest Neurological Skin/Lymph Nodes Ears/Hearing Eyes/Vision  *Circle One:  *Hearing Pass Pass Fail  *Vision Pass: Left / Right / Right / Right / Glasses: Y/N   |  |              |              |   |           |        |              |                     |           |  |
| Neurological Skin/Lymph Nodes Ears/Hearing Eyes/Vision *Circle One: *Hearing Pass Pass Fail  * Vision Pass: Left _ / _ Right _ / _ Right _ / _ Right _ / _ Glasses: Y/N   |  |              |              | Dr. Signature:  |           |        |              |                     |           |  |
| Neurological Skin/Lymph Nodes Ears/Hearing Eyes/Vision  *Circle One: *Hearing Pass Pass Fail  * Vision Pass: Left _ / _ Right _ / _ Right _ / _ Glasses: Y/N  | Extremities/Back/Chest   |              |              | Dr. Phone Number:   |           |        |              |                     |           |  |
| Ears/Hearing  Eyes/Vision  *Circle One:  *Hearing   | Neurological   |              |              | D1. I HOHE MUHIDEL.   |           |        |              |                     |           |  |
| Ears/Hearing  Eyes/Vision  *Circle One:  *Hearing  Pass  Fail  Vision  Pass: Left _ /_ Right _ /_ Glasses: Y / N  | Skin/Lymph Nodes   |              |              | Date of Exam:   |           |        |              |                     |           |  |
| *Circle One:  *Hearing  | Ears/Heari   | ng           |              |   | <b>-</b>  |        |              |                     |           |  |
| *Circle One:  *Hearing  | Eyes/Vision  | 1            |              |   |           |        |              |                     |           |  |
| * Vision Pass: Left/ Right/ Fail: Left/_ Right/_ Glasses: Y / N   |  |              |              |   |           |        |              |                     |           |  |
| Ť AUZIVAL   | *Hearing   |              |              |   |           |        |              |                     |           |  |
|   | * Vision   | Pass: Lef    | 't/ Rig      | ht/   | Fail: Lef | it/    |              | 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

White: FACS File Yellow: Parent Copy Revised 2/4/2021