Well Child Examination Form

SITE: j
CLASS: j **AM** ☐ **PM** ☒

Community Action Head Start
2475 Center St. NE
Salem, OR 97301
Fax: 503-581-3012 Phone: 503 -581-1152

Child's Name: _____ **Date of Birth:** 5 /5 /_____

Clinic Name/Address:	**Phone #:**
Physician's Name:	**Fax #:**

Exam Date: _____

Measurements: **Height** _____ **Weight** _____ **Blood Pressure** _____

Hct/Hgb* date: _____ Result: _____ Concerns? Yes☐/ No☐

Lead Screening date**: _____ Result:_____ Concerns? Yes☐/ No☐

TB Screening date: _____ ☐ Negative ☐ Skin Positive ☐ Not Indicated

*Hct/Hgb: Community Action Head Start guidelines require this lab work to be done if a) none has been done in past two years b) last test was abnormal or c) if medically indicated by risk assessment.
**Lead: EPSDT guidelines require lead screening at ages 12 and 24 months or between 36 and 72 months if not done previously.

Hearing: Pass☐/ Fail☐ **Vision**: Pass☐/ Fail☐

If child is diagnosed with any of the following conditions, please indicate:

❑Anemia ❑Hearing Difficulties ❑Vision Problems ❑Asthma ❒Diabetes ❒High Lead Level

Are there any conditions present that could impact the child's participation in the Head Start program (asthma, allergies, medication)?

❑ No ❑ Yes Condition: _____

_____

- If child is diagnosed with asthma or allergies, please complete the Head Start Health Management Plan.

Were any referrals made at the visit or are any further assessments needed?

☐ No ☐ Yes, please list name of specialist and reason for referral or assessment:

_____

❑ Child is up to date on scheduled health care/immunizations.
❑ Child requires additional treatment as indicated in the above section.

_____ _____
Signature of Examining Physician **Date**

Revised 4/17/15