Site/Class: _____

Well Child Examination Form for Infants and Toddlers

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

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

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

Exam Date: _____

Please circle exam: 2 m 4 m 6 m 9 m 12 m 15 m 18 m 24 m 3 y

Measurements: Height: _____ **Weight:** _____ **BMI:** _____

Test	Date	Result	Concerns?
TB			☐ Yes ☐ No
Hct/Hgb*			☐ Yes ☐ No
**Community Action Head Start guidelines require this lab work to be done if a) at 12 months b) last test was abnormal or c) if medically indicated by risk assessment*			
Lead Screening**			☐ Yes ☐ No
******EPSDT guidelines require lead screening at ages 12 and 24 months or between 36 and 72 months if not done previously.*			

Hearing	**Vision**
Pass / Fail	*Eye Alignment*: Symmetrical / Asymmetric *Red Reflex*: Normal / Abnormal

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 Early Head Start program (i.e. asthma, allergies, nutrition concerns, medications?)
☐ Yes ☐ No Condition: _____

Were any referrals made at the visit or are any further assessments needed?
☐ Yes ☐ No
If yes, reason for referral and name of specialist: _____

☐ 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