HEAD START HEALTH SCREENING

Child's Name _____ Exam date _____
Address _____ Birth date _____
Parent/Guardian Name _____ Phone # _____

REQUIRED SCREENINGS for Head Start/EPSDT (EXAMINER: PLEASE COMPLETE ALL AREAS BELOW)	
HEIGHT: _____ WEIGHT: _____ BMI: _____ B/P: _____ NUTRITIONAL STATUS: _____ URINALYSIS: Normal _____ Abnormal _____	ALLERGIES to food, medicine, environment: _____
HGB/HCT (MOST recent result): _____ Date: _____ SICKLE CELL : Trait _____ Disease _____	ASTHMA: No _____ Yes _____ Since what age? _____ Medication _____
LEAD LEVEL (MOST recent result): _____ Date: _____	Any concerns regarding this child's weight/height?
VISION: Pass _____ Fail _____ Unable to screen _____ Referred to:	Any concerns regarding this child's development?
HEARING: Pass _____ Fail _____ Unable to screen _____ Referred to:	Any concerns regarding this child's behavior?

PHYSICIAN-Please review all systems. Check below and mark any findings deviating from normal.

Normal Results?	YES	NO	Describe if abnormal	Normal Results?	YES	NO	Describe if abnormal
Appearance				Glands			
Posture/Gait				Heart			
Speech				Lungs			
Head				Bones/Joints			
Skin				Muscles			
Eyes/Vision				Abdomen			
Ears/Hearing				Genitalia			
Nose/Mouth				Other			

IMMUNIZATION HISTORY (or provide MCIR printout)

	Dose 1	Dose 2	Dose 3	Dose 4	Dose 5
DTaP					
IPV					
MMR					
Hib					
HepB					
PCV7					
VARICELLA					

TB test (Please circle): Yes/No Date given: Results:

Comments: _____
Should activities be restricted? No __ Yes *__ Explain* _____

Examiner's signature _____ Exam date _____

Examiner's Name (printed) _____ Phone _____
Address _____