WOOD COUNTY HEAD START, INC.
HEALTH EXAMINATION/ASSESSMENT FORM

For Office Use:
Admin Reviewed ☐

TO BE COMPLETED BY PARENT OR GUARDIAN

Child Name: **DOB:** Address(street, city, state, zip):

Parent/Guardian Name(Print): Address(street, city, state, zip):

MANDATORY SCREENING TESTS:

Laboratory Tests: **The Federal Head Start Program requires lead & hemoglobin levels on all Head Start children. EPSDT requires children to have a blood lead level drawn at 12 & 24 months of age. Children between the ages of 36 to 72 months must also have a blood lead test if a lead level had not been drawn at or after 24 months.**

1. Dates of Lead Screenings 1st:_____Result _____ 2nd:_____Result_____

2. Date of last Hemoglobin_____ Result _____ (if less than 11gm schedule to recheck in 2-3 months)

TO BE COMPLETED BY HEALTH PROFESSIONAL

1. Is this a Well Child Check? ☐ Yes ☐ No

Interval (e.g. 6 mos, 3 yr, etc)_____

2. Does the child have any pre-existing conditions? (list)

3. Instructions for the feeding and care of the child with special problems, including allergies (be specific).

Does the child have a milk allergy? ☐ Yes ☐ No

4. Was child's vision and/or hearing screened at this visit?

Vision ☐ Yes ☐ No
Method:_____
Results:_____
Referral made: ☐ Yes ☐ No

Hearing ☐ Yes ☐ No
Method:_____
Results:_____
Referral made: ☐ Yes ☐ No

5. Does this examination reveal any abnormality? (list)

Newly diagnosed as *Treatment needed*: ☐ Yes ☐ No Explain:_____
Have you arranged for follow-up? ☐ Yes ☐ No When:_____

6. Recommendations:

Physical Activity: ☐ Unrestricted ☐ Restricted Explain: _____

_____

Diet: ☐ Normal ☐ Special Explain: _____

_____

7. For medical reasons, this child should not receive the following immunizations.

8. Height _____ Weight_____

Blood Pressure_____/_____

I CERTIFY THAT I HAVE EXAMINED THE ABOVE CHILD ON THIS DATE AND THAT HE/SHE IS UP TO DATE ACCORDING TO THE EPSDT AND IS ABLE TO PARTICIPATE IN DAY CARE ACTIVITIES.

Signature of M.D., P.A. or Health Care Provider: _____ Examination Date: _____

Name(Print) _____ Address _____ Phone _____

PLEASE RETURN IMMEDIATELY TO:
Wood County Head Start, Inc.
1011 8th Street South
WI Rapids, WI 54494
Phone: (715) 421-2066 FAX (715) 421-2069

For Office Use
OPTION: PS I/T CENTER: HB B M N V W
SESSION: AM PM Teacher Initials: _____ FSW: _____

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