0-5 HEAD START — **EPSDT / SCREENINGS / PHYSICAL EXAMINATION / ASSESSMENT**

(Parents Complete This Section) — **EARLY CHILDHOOD FORM AGE 1 MONTH THROUGH 4 YEARS**

CHILD'S NAME:	**SEX:**	**BIRTHDATE:**
PARENT/GUARDIAN NAME:	**PHONE:**	**PRINT DOCTOR'S NAME:**
PARENT/GUARDIAN ADDRESS:		

0-5 HEAD START CENTER NAME AND ADDRESS: PHONE: (810) 591-3890
THE LEARNING COMMUNITY 1181 W. SCOTTWOOD AVE. FLINT, MI 48507 FAX: (810) 591-3650

I give permission for this information, and test results to be shared with my child's Health care provider and the Head Start Program **Parent Signature**____________ **Date of Exam:**________

SCREENING TESTS: ***All items are required by Head Start and recommended by the American Academy of Pediatrics for age one month through 4 year well child visits. At a minimum check appropriate boxes in RESULTS/DATE column and complete highlighted areas. Enter date if done previously. Provide comments on: services needed, suspect or atypical results and reasons services were not performed.***

TEST	RESULTS/DATE	COMMENTS
A. Age physical was preformed	**Yrs. Mos.**	**Immunizations given today:**
B. Immunization Review	☐Up to date ☐Immunizations Needed ☐Review Not Performed	
C. History	☐Performed ☐Not Performed	
D. Blood Pressure (*Perform at 3yr. and 4yr.*) **Result:** ______	☐Normal ☐Suspect ☐Atypical ☐Not Performed	
E. Height ____ **Weight** ____ (*Perform at each visit no shoes, to nearest 1/8 inch*) **Head circumference** ______ (*Perform at each visit up to 24 mo.*)	☐Normal ☐Suspect ☐Atypical ☐Not Performed	
F. Hearing Results: ______ (*Perform at each well visit between 0-3 years –subjective*) (*Perform at 3 years and 4 years- must be objective*)	☐Normal ☐Suspect ☐Atypical ☐Not Performed	
G. Vision Results: ______ (*Perform at each well visit between 0-3 years - subjective*) (*Perform at 3 years and 4 years- must be objective*)	☐Normal ☐Suspect ☐Atypical ☐Not Performed	
H. Developmental Assessment	☐Normal ☐Suspect ☐Atypical ☐Not Performed	
I. Blood Lead Results:______ (*Perform between 9-12 mo. and at 24 mo. If never tested, perform between 3yr. And 5yr*)	☐Normal ☐Suspect ☐Atypical ☐Reviewed--Not Performed	
J. Hematocrit or Hemoglobin Results ____ (*Perform between 9-12 mo. and as needed for high risk*).	☐Normal ☐Suspect ☐Atypical ☐Reviewed--Not Performed	
K. Cholesterol ☐ **Low Risk** (*Test High Risk child at 24 Mo., 3 yr. and 4 yr.*)	☐Normal ☐Suspect ☐Atypical ☐Reviewed--Not Performed	
L. Sickle Cell[1] (*Perform once between 6 Mo. and 20 yr.*)	☐Normal ☐Suspect ☐Atypical ☐Reviewed--Not Performed	
M. Nutritional Assessment	☐Normal ☐Suspect ☐Atypical ☐Not Performed	
N. Tuberculin (TB) Test[2] ☐ **High Risk** ☐ **Low Risk** (*12 Mo. if High Risk*)	☐Normal ☐Suspect ☐Atypical ☐Not Performed	
O. Interpretive Conference	☐Performed ☐Not Performed	
P. Anticipatory Guidance: *Violence Prevention; Injury Prevention; Sleep Positioning and Nutritional Counseling*	☐Performed ☐Not Performed	

1. The test should have been performed on children born in a Michigan hospital on or after 10/1/87. For other children with all or some black heritage, the test is required prior to the child's 21st birthday unless electrophoresis for sickle cell was done when the child was at least 6 months of age and the results are known to the parent.
2. Testing should be done upon recognition of high risk factors. If results are negative but high-risk situation continues, testing should be repeated on an annual basis.

PHYSICAL EXAMINATION / ASSESSMENT: *All items are required by Head Start and recommended by the American Academy of Pediatrics for children age 1 month through 4 years. Please check appropriate columns (Normal for Age; Atypical; or Not Evaluated) and provide comments on: services needed, atypical results/scores; behavior/mental health problems and reasons for items not evaluated.*

	Normal for Age	Atypical	Not Evaluated	COMMENTS *(Use additional sheets if necessary.)*
A. General Appearance				
B. Posture, Gait				
C. Speech				
D. Head				
E. Skin				
F. Eyes: *(1) External Aspects*				
(2) Optic Fundiscopic				
(3) Cover Test				
G. Ears: *(1) External & Canals*				
(2) Tympanic Membranes				
H. Nose, Mouth, Pharynx				
I. Teeth- *Dental screening at each well visit 0-3yrs. Dental Exam at 3&4 yrs.*				
J. Heart				
K. Lungs ***(include asthma)***				
L. Abdomen *(include hernia)*				
M. Genitalia				
N. Bones, Joints, Muscles				
O. Neurological / Social *(1) Gross Motor*				
(2) Fine Motor				
(3) Communication Skills				
(4) Cognitive				
(5) Self-Help Skills				
(6) Social Skills				
P. Glands *(Lymphatic/Thyroid)*				
Q. Muscular Coordination				

R. Allergies *(please list)*: ______________________________

____

S. General Statement on Child's Medical Status (Please included any behavior/mental health issues): ______________________________

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Should the child's activity be restricted due to physical defect or illness? ☐Yes ☐No

If yes, check below and explain degree of restriction: ☐Classroom ☐Playground ☐Gym ☐Swimming ☐Sports ☐Camp ☐Other

4. FINDINGS, TREATMENTS AND RECOMMENDATIONS

ABNORMAL FINDINGS / DIAGNOSIS	TREATMENT PLAN	RECOMMENDED FOLLOW-UP OR RESULTS	DATE

PHYSICIAN NAME AND ADDRESS (PLEASE PRINT): ______________________________

PHONE: ________________________ **FAX:** ________________________

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PHYSICIAN'S SIGNATURE **Date of Exam** REVIEWED BY______________

INITIALS (STAFF ONLY)