Skagit/Islands Head Start
Well Child Examination

Child's Name: ______________________________ Parent's Name: ______________________________

Birth Date:______________ Exam Date:______________ Head Start Center: ____________________

SECTION 1 – STANDARD TESTS & MEASUREMENTS (REQUIRED BY FEDERAL HEAD START GUIDELINES)

	Normal	Abnormal		Normal	Abnormal
Height ________ **Weight** __________	☐	☐	**Urine** ______________________	☐	☐
Vision ______________________	☐	☐	**Lead Screening** (fingerprick) ________	☐	☐
Hearing: ______________________	☐	☐	**HCT/HGB** (fingerprick) ____________	☐	☐
Blood Pressure _______ / ________	☐	☐			

SECTION 2 - PHYSICAL ASSESSMENT

	Normal	Abnormal	Not Examined		Normal	Abnormal	Not Examined
General Appearance	☐	☐	☐	Lungs	☐	☐	☐
Posture, Gait	☐	☐	☐	Abdomen (include hernia)	☐	☐	☐
Head	☐	☐	☐	Genitalia	☐	☐	☐
Skin	☐	☐	☐	Bones, Joints, Muscles	☐	☐	☐
Eyes: External aspects	☐	☐	☐	Neurological	☐	☐	☐
Cover Test	☐	☐	☐	Gross motor	☐	☐	☐
Ears: External Canal	☐	☐	☐	Fine motor	☐	☐	☐
Nose, Mouth and Pharynx	☐	☐	☐	Glands (Lymphatic/ Thyroid)	☐	☐	☐
Teeth	☐	☐	☐	Muscular Coordination	☐	☐	☐
Heart	☐	☐	☐	Other:	☐	☐	☐

SECTION 3 - HEALTH STATUS

1. Is child up-to-date on age appropriate and preventative health care? ☐ Yes ☐ No
2. Is child taking fluoride tablets? ☐ Yes ☐ No Were fluoride tablets prescribed today? ☐ Yes ☐ No
3. Were immunizations given today? ☐ Yes ☐ No **If yes, please attach current immunization record.**
4. Current Medications: ____
5. Allergies: ____
6. Child needs the following follow up: ☐ None ☐ Immunizations ☐ Dental Care ☐ Other:______________
7. Findings/Recommendations: ____
   ____
   ____
8. Next recommended appointment: ____________________

MEDICAL PROVIDER INFORMATION

Provider Name: Phone Number: ( ) -

Clinic Name (if different): Fax Number: ( ) -

Clinic Address:

PROVIDER'S SIGNATURE: **DATE:**