Washington State Department of CHILDREN, YOUTH & FAMILIES

ECEAP WELL CHILD EXAM

KENNEWICK SCHOOL DISTRICT

CHILD INFORMATION: To be completed by parents Home Language _____

Child's Name _____ Sex ☐M ☐ F Date of Birth _____ Age_____

Parents Name_____ Home Phone _____

Address _____ City _____ Zip _____

SCREENING TESTS: Required by ECEAP (to be completed by the Health Care Provider)

TEST	DATE	RESULTS
HEIGHT		
WEIGHT		
BLOOD PRESSURE		

PHYSICAL EXAMINATION/ASSESSMENT: Required by ECEAP (completed by Health Care Provider)

	NORMAL	ABNORMAL	NOT EVALUATED	COMMENTS
General Appearance				
Posture/Gait				
Head				
Skin				
Eyes				
Ears				
Nose/Throat				
Teeth/Mouth				
Heart				
Lungs				
Abdomen				
Muscular/Skeletal				
Neurological				

CHRONIC MEDICAL PROBLEMS: ☐Diabetes ☐Asthma ☐Seizures ☐Allergies (please list)_____

☐Other_____

RECOMMENDATIONS / Past Health History / Please list any abnormal blood tests or urinalysis.

GENERAL STATEMENT OF CHILD'S PHYSICAL STATUS:

Medications: _____

☐No Disability ☐ Physical Disability ☐Developmental Disability

_____ _____ _____

Name of Clinic Health Care Provider Signature Today's Date

PLEASE RETURN COMPLETED FORM TO:

KENNEWICK SCHOOL DISTRICT
ECEAP OFFICE
1000 W. 4TH AVENUE
KENNEWICK, WA 99336
FAX: 509-222-5037