Emanuel County Early Head Start
308 Tiger Trail
Swainsboro, GA 30401
OFFICE# (478)237-3434 FAX# (478)419-1187

VERIFICATION OF WELL BABY CHECK (2-6 MONTHS)

Child's Name: _____ Birthdate: _____ Sex: M F

Staff Person Requesting Information: Jennifer Kelly Date of Exam: _____

TO BE COMPLETED BY HEALTH CARE PROVIDER:

Child's overall physical status is:

[ ] Normal for Age (WNL)
Next exam date: _____

[ ] Abnormal/Referral
Child was referred for: _____
Follow-up appointment date: _____

HEALTH SCREENINGS AND EXAMS AS REQUIRED BY THE GEORGIA HEALTH CHECK SERVICES (EPSDT)

WELL BABY CHECK (PLEASE CHECK): [ ] 2 MONTH [ ] 4 MONTH [ ] 6 MONTH

HEALTH CHECK SERVICES:	**RESULTS OF EXAM/SCREENINGS**
Health History:	[ ] Completed [ ] Updated_____
Height & Weight:	Hgt: _____ Wgt: _____lbs _____oz
Head Circumference:	_____cm
Hearing (subjective up to age 4):	***[ ] Passed [ ] Failed***
Vision (subjective):	***[ ] Passed [ ] Failed***
Developmental/Behavioral Assess:	***[ ] WNL [ ] Needs further evaluation***
Physical Exam:	***[ ] Passed [ ] Failed***
Dental Screening (inspection of mouth):	**[ ] No problems [ ] Referred**
	Date of referral: _____
	Dentist referred to: _____

PLEASE LIST ABNORMAL FINDINGS, TREATMENT PLANS, AND RECOMMENDATIONS ON THE BACK

_____ _____ _____
Printed Name of Health Provider Signature of Health Provider Date

_____ _____
Address Telephone Number

ABNORMAL FINDINGS/DIAGNOSES	TREATMENT PLAN	RECOMMENDED FOLLOW-UP OR RESULTS	DATE
a.			
b.			
c.			
d.			

Comments/Notes: