Emanuel County Early Head Start 308 Tiger Trail Swainsboro, GA 30401

VERIFICATION OF WEL	L BABY CHECK (9-36 MONTHS)
Child's Name:	Birthdate: Sex: M	
Staff Person Requesting Information:	nifer Kelly Date of Ex	xam:
TO BE COMPLETED BY HEALTH CA	RE PROVIDER:	
Child's overall physical status is:		
[] Normal for Age (WNL) Next exam date:	Follow-up appointment	t date:
WELL BABY CHECK (PLEASE CHECK): []		15 MO [] 18 MO
HEALTH CHECK SERVICES: Health History: Height & Weight: Head Circumference: (up to 30 months) Hearing (subjective up to age 4): Vision (subjective up to 30 months): Developmental Screening: Autism Screening (18 and 24 months): Physical Exam: Hematocrit or Hemoglobin (btwn 9-12 months) Blood Lead Test (12 and 24 months): Dental Screening (inspection of mouth):	[] Completed [] U Hgt: Wg	[] Failed [] Failed [] Needs further evaluation [] Needs further evaluation [] Failed Result: Result:
Printed Name of Health Provider Signa	ture of Health Provider	ENDATIONS ON THE BACK Date
Address		ephone Number

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