EARLY HEAD START/ HEAD START HEALTH APPRAISAL
OAKLAND LIVINGSTON HUMAN SERVICE AGENCY

Child's Name _____ **Date of Birth** _____ **Date of Exam** _____**Age**_____

Head Start requires that all AAP/ EPSDT recommendations for each well child visit are completed. Please complete areas assessed.

Weight _____ **Length** _____ **Head Circ.** _____ **BMI** _____

B/P @ age 3-5 years _____/_____ **Does the child need Fluoride supplements? Yes** _____ **No** _____
Was a Fluoride RX given to the family? Yes _____ **No** _____

LABS:
Hgb/Hct @ 12 months Date _____ Result_____
Lead Level @ 12 mo. and 24 mo. Date_____ Result_____
Lipid risk assessment @ 2 and 4 years of age Risks/Concerns:_____
TB risk assessment Date_____ Result_____

MEDICAL PROVIDER (Please check all areas assessed during this visit.)

	WNL	ABNL	Describe if abnormal		WNL	ABNL	Describe if abnormal
Appearance				**Abdomen**			
Head/Skull				**Genitourinary**			
Skin/Rashes/Bruising				**Bones/Joints/Muscles**			
Eyes – Vision				**Neurological/Social**			
Ears – Hearing				**Glands**			
Nose/Mouth/Pharynx				**Muscle Coordination**			
Teeth				**Gait/Posture**			
Heart				**Other**			
Lungs							

DEVELOPMENTAL/BEHAVIORAL ASSESSMENTS	**WNL**	**Comments/Concerns**
Developmental screening tool @ 9 mo. 18 mo. 30 mo.		
Autism screening tool @ 18 mo. and 24 mo.		
Development assessed @ each well child visit		

STANDARDIZED TESTS:
Hearing Screening (OAE): No_____ **Yes**_____ **Normal** _____ **Abnormal** _____**Date**_____
Vision Screening (Pediavision/Sure Sight): No_____ **Yes**_____ **Normal** _____ **Abnormal** _____**Date**_____

IMMUNIZATIONS:
Is child up-to-date on immunizations?
Yes_____ No_____ If no please indicate reason_____

Please attach a copy of the current immunization record.

Please indicate if child has been treated for any of the following:
Anemia_____ **Asthma** _____ **Diabetes**_____
Vision Issues_____ **Hearing Issues**_____ **High Lead levels**_____
Overweight/underweight_____ **Allergies**_____

Should the child's activities be restricted: No _____ **Yes** _____ **Concerns:** _____
Has child been referred to a specialist? No _____ **Yes** _____ **Concerns:** _____
*Additional Comments/Recommendations:*_____
_____

Provider's Signature _____**Printed Name:** _____ **Date:**_____
Address _____ **Phone#**_____
Next Scheduled Visit: _____ **months/year**