DCIU EHS Well Child Physical Examination

Section I

Child's Name (last)	(First)	Gender	Date of Biirth
		___ Male ___ Female	

Parent/Guardian Name	Telephone Number	Center/Room

I give my consent for my child's Physician and Child Care Provider to discuss my child's health concerns

Parent/Guardian Signature Date:

Section II – To be completed by Health Care Provider:

Well Child Exam Date:__________________

Please circle WCE performed today 0 2 4 6 9 12 15 18 24 30 36 months

Length/Height: ______________ Weight: ____________________ BMI:_____________________

Head circumference (up to 24 months) _____________

	Normal	Abnormal	Referred	Not Evaluated	Comments
SENSORY SCREENING					
Vision					
Hearing					
DEVELOPEMENTAL/BEHAVIORAL ASSESSMENTS					
Developmental Screening					
Psychosocial /Behavioral Assessments					
PHYSICAL EXAMINATION					
Hematocrit or Hemoglobin					
Lead Screening					
Tuberculin Test					
ORAL HEALTH					
ANTICIPATORY GUIDANCE					
Section III- Immunizations	**Date**	**Date**	**Date**	**Date**	**Comments: Medical Exempts/ Refusal**
Hepatitis B					
Rotavirus					
Dipth./Tetanus/Pertussis					
Haemophilus Influenza Type B					
Pneumococcal					
Inactivated Poliovirus					
Influenza					
Measles, Mumps, Rubella					
Varicella					
Hepatitis A					
Meningococcal					

Health Problems, Allergies, or Special Needs; Recommended Treatment/Medications/Special Care.

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(Please list here)

____ None

Next Appointment Date:_______________

Medical Care Provider or Name of Healthcare Provider: ____

Signature of Health Care Provider: ____

License Number: ______________________________

Address: ____

Phone: _______________________________

Date Form Signed: _________________________

Please attach any plans of care to this form