

San Juan Unified School District- Early Childhood Education
EARLY HEAD START WELL CHILD EXAM (TO BE COMPLETED BY PROVIDER)

*Staff: Use this form for
0-30 MONTHS only
for 3yo, use PE form*

ATTENTION: Head Start requires a COMPLETE CHDP EQUIVALENT HEALTH EXAM, including **LEAD BLOOD TEST** (12 & 24 mos) and a 12 month **HEMOGLOBIN**, for the child to participate in the Early Head Start Program. **Please complete ALL boxes, sign and date.** Return form to parent or fax to (916) 273-5647.

CHILD'S NAME	DATE OF BIRTH	SCHOOL SITE
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WELL CHILD EXAM PERFORMED TODAY (CHECK ONE)	
☐ < 1 MO ☐ 2 MOS ☐ 4 MOS ☐ 6 MOS ☐ 9 MOS ☐ 12 MOS ☐ 15 MOS ☐ 18 MOS ☐ 24 MOS ☐ 30 MOS	

EXAM RESULTS				
DATE OF EXAM	LENGTH	WEIGHT	HEAD CIRCUMFERENCE	ALLERGIES ☐ NKA ☐ Life threatening LIST: _____

PHYSICAL EXAM RESULTS	WNL	Abnormal	N/A
Constitutional			
HEENT			
Functional Vision & Hearing			
Cardiovascular			
Respiratory			
GI/Diet/Nutrition			
Musculoskeletal			
Integumentary			
Neurological			
Genitourinary			
Endocrine			
Hematologic/Lymphatic			
Allergic/Immunologic			
Developmental			
Speech			
Behavioral/Psychosocial			
TB Risk Assessment	☐ At Risk, TB test req'd		
Lead Risk Assessment	☐ At Risk, lead test req'd		
Anemia Risk Assessment	☐ At Risk, anemia test req'd		
Oral Health Risk Assessment			☐ N/A
Dental Screening	☐ Yes	☐ Referred	☐ No
Fluoride varnish applied ?	☐ Yes		☐ No

Anemia Test Results (Medicaid req'd at 12 mos)			
12 Mo Hgb	Test Date	Result	☐ Ordered
2- 5 yr Hgb	Test Date	Result	☐ Ordered
☐ At Risk	Test Date	Result	☐ Ordered
Treatment/Follow-up: _____			

Lead Test Results (Medicaid req'd at 12 & 24 mo)			
12 Mo Lead	Test Date	Result	☐ Ordered
24 Mo Lead	Test Date	Result	☐ Ordered
☐ At Risk	Test Date	Result	☐ Ordered
Treatment/Follow-up: _____			

TB Test Results			
☐ Not at risk	☐ At risk	☐ TB test ordered	
☐ QuantiFERON	Test Date	Result:	☐ Negative
☐ TST/PPD			☐ Positive
Treatment/Follow-up: _____			

IMMUNIZATIONS GIVEN TODAY	
<i>Please attach copy of IZ record</i>	
☐ DTaP ☐ IPV ☐ Hep B ☐ Hib* ☐ PCV ☐ Rotavirus ☐ MMR ☐ Varicella ☐ Influenza ☐ Other: _____	*ONE HIB REQ'D ON/AFTER 1ST BDAY FOR CHILDCARE

Findings from above:					
Health Concerns/ Diagnoses:					
Medications Taken At Home:	☐ No ☐ Yes	List	Medication required at school?	☐ No ☐ Yes	List meds at school - Need Med Auth:
Recommend full participation in normal daily activities at school (if no, explain in space provided):	☐ Yes	☐ No, explain:			
Treatment, Restrictions, Recommendations for School:					
Next Well Child Appt Date: ____/____/____					

CLINIC STAMP

Health Care Provider Signature: _____

Date: _____

PRINT Provider Name: _____