JEFFERSON COUNTY HEAD START

Serving Jefferson, Clear Creek, Gilpin, and Park counties

PHYSICAL EXAMINATION/WELL-CHILD CHECK

CHILD'S NAME:	**CENTER/CLASS:**	**BIRTHDATE:**

TO BE COMPLETED BY THE HEALTH CARE PROVIDER

Date of Exam:	**Temp** ______	**Pulse** _____	**BP**______/______	**Height**_____ **Weight** _______	**BMI** ______

Allergies:	**Current Medications:**

Did this child received a **blood lead test** at or around 24 months of age? □ Yes □ No

Date of test: _________

Results: _____mcg/dL □ Normal □ Abnormal

If this child has not had a lead test, please perform one as required by Federal Head Start Performance Standards and Medicaid.

Date of most recent **hemoglobin test**: _________

Results: ____gm/dL or ____% □ Normal □ Abnormal

Is child at risk for TB? □ Yes □ No

If yes, date of TB test: ________ Results: □ Negative □ Positive

Child Health History:

History of birth injury, abnormal growth/development, congenital defects? ____

____

Significant acute or chronic medical problems? _____________

____

____

Significant behavior/emotional concerns? _________________

____

Special diet requirements? ____________________________

____

Any concerns regarding child's growth or weight? __________

____

Do the child's activities need to be modified because of the above or other circumstances? ______________________________

____

Physical Examination/Well-Child Check:

Hearing Screening: □ not done □ Pass □ Referral

What type of screening? □ OAE □ Audiometer □ other _________

Vision Screening: □ not done □ Pass □ Referral

What type of screening? □ LEA/Snellen □ photo-screener □ other ____

Development: (Circle any areas of concern)

Adaptive/Cognitive Language/Communication

Gross Motor Social/Emotional Fine Motor

Was an Adverse Childhood Experiences (ACE) screening performed? □ Yes □ No

Date of test: _________ Score: _______

Describe any abnormal findings of physical exam and comments:

____

____

____

____

____

____

Immunizations given today: ______________________

____

If immunizations were given today, a signed Colorado Certificate of Immunization must be submitted to Jefferson County Head Start with this evaluation.

______ (initial) **I hereby certify that the above-named child is in good health and is of normal physical and emotional maturity for age except as already noted. The child may fully participate in the program.**

IS THIS THE CHILD'S MEDICAL HOME? □ YES □ NO

NAME OF CLINIC/OFFICE (PLEASE PRINT):

PHONE NUMBER:

FAX NUMBER:

SIGNATURE OF HEALTH CARE PROVIDER:

NEXT EXAM DATE:

Return Fax: 720-898-0664 Return Email: ______________________