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

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:

____
____
____
____
____
____

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? _______________________________
____

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: 720-497-7989 **Return Email: ahsfax@co.jefferson.co.us**

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