

ThrivAlaska Head Start Birth to Five Well Child Check Form

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Fairbanks, AK. 99701 f (907) 452-4203

Child's Name:			Date of exam:		
Child's Age:		Child's DOB:		Parent or Guardian's name:	
Height:	Weight:	BMI (2-5 yrs.):	Blood Pressure (3-5 yrs.):	Head Circumference (0-12mo.):	

MANDATORY HEAD START TESTS INCLUDING EPSDT

Hemoglobin (min. age of 9 months)(results): NOTES / Results:		Lead Screening (required at 12 mo. & 24 mo. If not completed, required between ages of 3-5 yrs.) • Screened • Not Screened NOTES / Results:			
TB Skin Test (once between the age of 1-2 years, and once between 3-5 years)		Date administered:		Date Read: Notes / Results:	

HEALTH FACTORS REVIEWED:

		NOT				NOTES
		NORMAL	ABNORMAL	REFER	EXAMINED	

		NORMAL	ABNORMAL	REFER	EXAMINED	NOTES
1.	General Appearance					
2.	Posture, Gait					
3.	Skin					
4.	Eyes/Vision					
5.	Ears/Hearing					
6.	Nose, Mouth, Pharynx					
7.	Teeth/Gums					
8.	Heart					
9.	Lungs					
10.	Abdomen					
11.	Bones, joints, muscles					
12.	Glands (Lymphatic/Thyroid)					
13.	Fine motor					
14.	Gross Motor					
15.	Muscular Coordination					

DISEASE PREVENTION AND RECOMMENDATIONS

1.	Is child up-to-date on a schedule of age appropriate preventative and primary health care (Including Immunizations)? • Yes • No NOTES:
2.	Does the child need to establish any of the following services? • Routine Dental Care • Routine Hearing Screening • Mental Health • Evaluation by Registered Dietician • Speech and Language • Other:
3.	List any acute or chronic conditions, including allergies, if any: Child's Health Status was determined by: • Parent report • Medical history • Today's exam
4.	Is the child currently taking fluoride supplements? • Yes • No NOTES:
5.	Was there a developmental screening completed today with the child? • Yes • No NOTES (which screening, results, etc.):

PROVIDER INFORMATION

PROVIDER NAME:	Provider Signature:	Date:
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Clinic Name: _____ Fax: _____

I give permission for the most recent well child check to be obtained by Play N Learn Prenatal to 5 Community Head Start Attn: Health and Safety, at 452-4203.

Parent Signature: _____
Form received _____ (staff initials) date _____
Revised 8/15/15

Date: _____
Entered in CP _____ (HSC initials) date _____
Performance Standard Section Health and Safety 1304