

Early Childhood Development and Health Services

**Well Check (Early Head Start)**

Students Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Parent/Guardian Name \_\_\_\_\_ Phone # \_\_\_\_\_

Address \_\_\_\_\_

Center Base \_\_\_\_\_  Home Base \_\_\_\_\_ Teacher \_\_\_\_\_

*The child listed above is being evaluated for readiness to enter Preschool. OCHS operates part day and full day programs. Utilizing this form, please provide up-to-date information on the child referenced above.*

**Exchange of Information/Intercambio de Información**

As the parent of the child referenced above, I hereby authorize the release of the information contained in this document to be provided to Orange County Head Start, Inc.

*Como el padre/tutor del niño identificado en este formulario, yo autorizo el intercambio de información médica que se encuentra en este documento a Orange County Head Start, Inc.*

Parent Signature/*Firma de padre* \_\_\_\_\_ Date/*Fecha* \_\_\_\_\_

**HEAD START follows the CHDP requirements. All sections must be completed. (For Provider Use Only)**

Well Check (please mark one):  3-5 days  1 month  2 month  4 month  6 month  9 month  12 month  
 15 month  18 month  24 month  30 month

**General Health**

Height/Length \_\_\_\_\_

Weight \_\_\_\_\_

Head Circumference \_\_\_\_\_

(Required at 0-24 months) \_\_\_\_\_

**TB Risk Assessment**

(Required at 1,6,12,24 months)

Screened, not at risk

**TB Skin Test (If at risk)**

Given Date \_\_\_\_\_

Read Date \_\_\_\_\_

Results \_\_\_\_\_

MM Induration \_\_\_\_\_

**Appropriate Developmental Milestones for Age**

Yes  No (if no, fill out below)

What delays? \_\_\_\_\_

\_\_\_\_\_

Referrals? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Attach Copy of Up-to-Date Immunization Records**

**HGB/HCT Screen (Required at 12 months)**

Hgb \_\_\_\_\_ or Hct \_\_\_\_\_

Iron Prescribed:  Yes  No

Re-check Date \_\_\_\_\_

**Lead Screen (Required at 12 & 24 months)**

Screened, not at risk

Screened, at risk

Lead value (if at risk): \_\_\_\_\_

**Newborn Blood Screening**

Completed, no concern

Completed, concern noted

Follow-up date: \_\_\_\_\_

**Physical Examination**

	NORM	ABNORM		NORM	ABNORM		NORM	ABNORM
GEN.APPEARANCE			GLANDS			BACK		
POSTURE			HEART			MOUTH/TEETH		
SPEECH			LUNGS			ORAL HEALTH SERVICES PROVIDED?	YES	NO
HEAD/NECK			ABDOMEN			(Ages: 12, 18, 24, 30 months only)		
EYES			GENITALIA			If No, was the child referred to a Dental Home?	YES	NO
EARS			BONES/JOINTS/MUSCLE					
NOSE			SKIN					

**Explain any abnormal findings/statement of health:**

Referred to: \_\_\_\_\_

For: \_\_\_\_\_

**Physician Information(Stamp):**

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone #: \_\_\_\_\_

Signature \_\_\_\_\_

Date of Exam: \_\_\_\_\_

Fax #: \_\_\_\_\_