Orange County Head Start, Inc.

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.

*Là Phụ huynh của con tôi sau đây. Tôi bằng lòng cung cấp những thông tin sức khoẻ trong văn bản này cho cơ quan Quận Cam Head Start, Inc.*

Parent Signature/ *Phụ Huynh Ký tên* _____ Date/ *Ngày* _____

**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? **(Ages: 12, 18, 24, 30 months only)** | YES | NO |
| HEAD/NECK | | | ABDOMEN | | | | | |
| 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:_____ **Signature:** _____
Address:_____ **Date of Exam:** _____
Phone #:_____ **Fax #:** _____