Head Start/Early Head Start
Health Services Coordinator
126 Woodlake Drive SE
Rochester, MN 55904

507.424.1532 ~ Fax 507.287.2411

New Name. Same Mission. Putting Families First.
Child Care Resource & Referral | Families First OF MINNESOTA

HEAD START WELL CHILD EXAM

☐_____**month WC** ☐ **3 year** ☐ **4 year** ☐ **5 year**

Child's Name: _____ Date of Birth: _____ Sex: _____

Physician's Name:_____ **Date of Exam**: _____

Name of Clinic: _____ Medical Record #: _____

Please note: These items are <u>Federally Mandated</u> for Head Start children in accordance with the MN EPSDT schedule of age-related standards
*****Please provide previous applicable lab results*****

Head Circumference _____cm/inches. **Height** _____cm/inches**.** **Weight** _____kg/lbs**. Blood Pressure**_____**/**_____

Hearing Right Ear _____**DB** □Normal □Abnormal □Question Validity/Retest □Refer
Left Ear _____**DB** □Normal □Abnormal □Question Validity/Retest □Refer

Vision Right Eye____/____ □Normal □Refer to Eye Clinic □Question Validity/Retest
Left Eye____/____ □Normal □Refer to Eye Clinic □Question Validity/Retest

HGB* Results_____ Date _____ **Lead*** Results_____ Date_____ **TB Questionnaire**___ **High Risk** Yes or No
(*Please provide HCT/HGB & Lead results from the child's 9, 12 or 24 month Well Child Exam* Past lab results accepted)
Immunizations current? Yes or No **Please attach a copy of child's immunization record.**

Area	N/AB	Comments	Area	N/AB	Comments
1. Head			10. Spine		
2. Face			11. Cardiovascular		
3. Neck			12. Abdomen		
4. Eyes			13. Genitalia		
5. Ears			14. Extremities		
6. Nose			15. Joints		
7. Mouth			16. Muscle Tone		
8. Throat			17. Skin		
9. Chest			18. Neurological		
APGAR SCORES: 1 minute: _____ 5 minutes: _____					

1. Does child have any allergies? (food, drug, insect, other) No Yes If yes, please circle type and give recommendations:

   _____

2. Is child developing appropriately for his/her age? No Yes If no, what modifications are needed: _____
3. Is a special diet necessary? No Yes Please identify restrictions: _____
4. Is there a condition which may result in an emergency? No Yes Please specify: _____
5. Please indicate any notable health problems: _____
6. If noted, any restrictions or recommendations: _____
7. Referrals:_____

Printed Health Provider Name_____ Provider Signature_____

Parent/Guardian Signature_____ Date_____

I authorize this information to be mailed or faxed from my medical facility to Head Start. 126 Woodlake Drive SE, Rochester MN 55904 or faxed to: (507-287-2411)