Families First of Minnesota – HS/EHS
126 Woodlake Drive SE, Rochester, MN 55904
507-424-1532 Fax: 507-287-2411

New Name. Same Mission. Putting Families First.

# Head Start/Early Head Start Well Child Exam

**ALL** areas **MUST BE COMPLETED** by a medical provider for the Head Start/Early Head Start program

| **Child's Name:** | **Birthdate:** |
|---|---|
| **Clinic Name:** | **Exam Date:** |

☐2 mth ☐4 mth ☐6 mth ☐9 mth ☐12 mth ☐15 mth ☐18 mth ☐24 mth ☐30 mth ☐3 year ☐4 year ☐5 year

| Height: | Weight: | Head Circ: | Blood Pressure: |
|---|---|---|---|

**LAB RESULTS** - past results accepted

HGB: Date:

Blood Lead: Date:

**High Risk for TB?**

◯ YES ◯ NO

**Is child up to date on EPSDT schedule?**

◯ YES ◯ NO

**Immunizations Up-to-Date:**

◯ YES ◯ NO

Include Immunization Record

**Hearing & Vision Screening**

Newborn Hearing Screening (0-3 year olds):
◯ Pass ◯ Refer ◯ Not Done

Hearing Screening (3-5 year olds):
◯ Pass ◯ Refer ◯ Attempt ◯ Not Done

Vision Screening (0-5 year olds):
◯ Pass ◯ Refer ◯ Attempt ◯ Not Done

| Area | N/AB | Comments | Area | N/AB | Comments |
|---|---|---|---|---|---|
| HEENT | | | Back/Spine | | |
| Dental/Oral | | | Neurologic | | |
| Cardiac | | | Extremities | | |
| Lungs | | | Genitalia | | |
| Abdomen | | | Skin | | |

Does the child have allergies (food, medication, insect, other)? ◯ YES ◯ NO
**If Yes**, allergy documentation on the back **MUST** be completed.

Are there dietary restrictions or is a special diet required? ◯ YES ◯ NO
If yes, please describe.

Does the child have any chronic or notable health problems? ◯ YES ◯ NO
If yes, please list.

Are medications or treatments prescribed that are required at the childcare center? ◯ YES ◯ NO
(epinephrine, rescue inhaler, insulin, seizure medication, other)
If yes, please list.

Does the child have social, emotional or behavioral concerns? ◯ YES ◯ NO
If yes, please describe.

Is there any condition present that may result in an emergency? ◯ YES ◯ NO
If yes, please describe.

Indicate any restrictions or recommendations:

Please list any referrals that were made.

Medical Provider's Name (printed): _____

Medical Provider's Signature: _____ Date: _____

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# Individualized Health Plan - Allergy

| **Child's Name:** | **Birthdate:** |
|---|---|
| | |

## ALLERGY INFORMATION

| **Allergy/Allergies:** | *Allergies with similar symptoms can be listed together. Additional forms should be used for allergies with different triggers, symptoms, & techniques.<br>*Food allergies will require a separate Special Diet Statement signed by a medical provider |
|---|---|
| **What triggers the allergy?**<br>☐ Eating or ingesting the allergen<br>☐ Touching or contact with the allergen<br>☐ Insect sting or bite<br>☐ Inhalation (breathing) of allergen<br>☐ Other (list): | **Symptoms:** (Please select all known symptoms)<br>☐ No history of symptoms or unknown<br>☐ Mouth: Itching; tingling; swelling of lips, tongue or mouth ("mouth feels funny")<br>☐ Skin: Hives; itchy rash; swelling of the face or extremities<br>☐ Gut: Nausea; abdominal cramps; vomiting; diarrhea<br>☐ Throat: Difficulty swallowing; hoarseness; hacking cough<br>☐ Lungs: Shortness of breath; repetitive coughing; wheezing<br>☐ Heart: Weak or fast pulse; low blood pressure; fainting; pale; blueness<br>☐ Other (list): |
| **What procedures will be taken to respond to an allergic reaction for this child?**<br>☐ Notify parent/guardian.<br>☐ Administer medication as prescribed by medical provider.<br>☐ Follow Anaphylaxis Action Plan from the medical provider (attach to IHP).<br>☐ Call 911/EMS as needed and for signs of anaphylaxis or if epinephrine is administered.<br>☐ Other (list): | |

## MEDICATION INSTRUCTIONS FROM MEDICAL PROVIDER

Are medications **required** for response to an allergic reaction for this child? ☐ Yes ☐ No

*If yes, the medication will need to be kept at the center with written administration instructions from the medical provider and a medication authorization signed by the parent/guardian.

Medication & Dosage:

Indications for administration:

| Provider's Name: | Phone Number: |
|---|---|
| Provider's Signature: | Date: |

Please include child's allergy/anaphylaxis action plan if one has been developed.