

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.



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 Federally Mandated 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: _____					

- Does child have any allergies? (food, drug, insect, other) No Yes If yes, please circle type and give recommendations: _____
- Is child developing appropriately for his/her age? No Yes If no, what modifications are needed: _____
- Is a special diet necessary? No Yes Please identify restrictions: _____
- Is there a condition which may result in an emergency? No Yes Please specify: _____
- Please indicate any notable health problems: _____
- If noted, any restrictions or recommendations: _____
- 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)