** Well-Child Physical Examination Form/Formulario de Examen Físico para Niños Sanos**

This form can be faxed directly to Head Start at 801-781-3443

**Thank you**

For HS Staff Use Only:

Date of parent permission form (HSAP1): \_\_\_\_\_\_\_\_\_\_

**Child’s Name**/**Nombre del Nino**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **DOB/Fecha de Nacimiento:** \_\_\_\_\_\_\_\_\_\_\_

**Insurance provider/Proveedor de Seguros:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Clinic Name or Physician**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Clinic Phone**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**\*Parents-** Head Start needs a copy of this form to complete your child’s file. After completion, clinic please email or fax directly to Head Start/Early Head Start at rzagrodnik@owcap.org or Fax to 801-781-3443.

**\*Padres** Head Start necesita una copia de este formulario para completar el archivo de su hijo. Después de la finalización, envíe un correo electrónico o fax directamente a Head Start/Early Head Start a rzagrodnik@owcap.org o

envíe un fax al 801-781-3443.

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Exam Date:** | | |  | | | | |
| **Blood Pressure value**: \_\_\_\_/\_\_\_\_mmHg  Pass\_\_\_\_\_ Fail\_\_\_\_\_\_  **Blood Lead Level Test value:**  Pass\_\_\_\_\_ Fail\_\_\_\_\_\_  **Hemoglobin or Hematocrit value**:  Pass\_\_\_\_\_ Fail\_\_\_\_\_\_ | | | **Height**\_\_\_\_\_\_\_\_\_\_ **Weight**\_\_\_\_\_\_\_\_\_\_  **Head Circumference:** (if 24 months or younger): \_\_\_\_\_\_\_\_\_\_\_\_\_\_  Are there concerns about this child’s growth? **YES\_\_\_\_ NO\_\_\_\_**  **Vision Screening Tool or Value: \_\_\_\_\_\_\_\_\_\_\_\_**  Pass\_\_\_\_\_\_ Fail\_\_\_\_\_\_\_\_\_  **Hearing Screening Tool (OAE or Pure Tone)**: **Circle One**  Pass\_\_\_\_\_\_ Fail\_\_\_\_\_\_\_\_  **Autism Screener 18 mos. Or 24 Months:**  Pass\_\_\_\_\_\_\_ Fail\_\_\_\_\_\_\_\_ | | | | |
| Evaluation | **Normal** | Abnormal Findings | Evaluation | Normal | **Abnormal Findings** | **Does the child have any of the conditions below?** | |
| General Appearance |  |  | Genito-urinary |  |  |  | Yes |
| Posture |  |  | Bones, Joints |  |  | Asthma |  |
| Skin |  |  | Gross Motor |  |  | Diabetes |  |
| Head, Hair |  |  | Fine Motor |  |  | Allergies |  |
| Eyes: PERRL, EOM |  |  | Muscles |  |  | Seizures |  |
| Ears: cerumen |  |  | Lymph Nodes |  |  | Cerebral Palsy |  |
| Nose |  |  | Abdomen |  |  | Cancer |  |
| Mouth, teeth, pharynx |  |  | Reflexes |  |  | Spina-Bifida |  |
| Neck, thyroid |  |  | Neurological |  |  | Disabilities |  |
| Heart & Circulatory |  |  | Spinal Alignment |  |  | Autism |  |
| Chest & Lungs |  |  | Social Development |  |  | Malnutrition |  |

***Normal Well-Child Exam*** **OR *Concerns Identified (Please list below):***

Comments: Please list any additional health concerns (and on-going treatments). \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| --- | --- | --- |
| **Abnormal Findings or Concerns** | Treatment Plan | Recommended Follow-up |
|  |  |  |
|  |  |  |
|  |  |  |

**Clinic Stamp or Physician’s Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**