South Carolina Early Head Start/Head Start

Well Child Check

Child's Name: _____ DOB: _____ Date of Exam: _____Center: _____

SCDHEC IMMUNIZATION CERTIFICATE IS REQUIRED. Next imm. appt. _____

Check Appropriate Well Child Assessment:

☐ **Newborn** ☐ **2 Mos** ☐ **4 Mos** ☐ **6 Mos** ☐ **9 Mos** ☐ **12 Mos** ☐ **15 Mos** ☐ **18 Mos** ☐ **24 Mos** ☐ **36 Mos Other:____**

Dear Provider: Our Federal Program MUST follow South Carolina State EPSDT standards.

REQUIRED TESTS

Height or Length _____ in/cm Weight _____ lbs_____ oz or _____ kilograms

Head Circumference (under 2 yrs.) _____in/cm Blood Pressure Date: _____ Results:_____

Hgb and/or Hct (due at age 12 mo) Date:_____ Results:_____ Other:_____ Results:_____

Blood Lead Level (due at 12/24 mo) 1st_____ Results:_____ 2nd _____ Results:_____

Sensory Screenings

Ages 0-3

Vision: ☐ Normal ☐ Abnormal

Hearing:☐ Normal ☐ Abnormal

Ages 3-5 *(record vision 20/30, 20/40,etc.)*

Vision: Right eye _____ Left eye _____

Hearing: Right Ear: ☐ Pass ☐ Fail Left Ear: ☐ Pass ☐ Fail

PHYSICAL EXAM RESULTS:

Head:	Eyes:	Ears:
Nose:	Oral Screening:	Lymph nodes:
Skin:	Chest:	Speech:
Abdomen:	Genitalia:	Orthopedic:
Nervous System:	Muscular:	
Behavior/Development:	Heart/Lungs:	

List Allergies and reaction to foods, meds, insects, etc.	**Special Diet Order: (Separate Form)**

Medication during Head Start hours: (Separate Form)	**List Med(s):**	**Dosage**	**Frequency**	☐ ***No*** Meds during Head Start hours ☐ Physician authorizes child ***may*** receive meds during Head Start hours
List Condition requiring med(s):				

Physician Specific Concerns/Referrals:

_____

_____

☐ The child may participate in Head Start/Early Head Start with **NO** health-related restrictions.

☐ The child may participate **with these restrictions**: _____

☐ Next physical appt _____ ☐ Next follow- up appt _____ for _____

Provider_____ Address:_____Phone_____

Examining Health Professional: _____/_____/_____

PRINT NAME SIGNATURE DATE

Form completed by: (if different) _____/_____/_____

PRINT NAME SIGNATURE DATE

Consent to Fax this form: _____Date: _____ Center Fax #_____

PARENT'S SIGNATURE