



# South Carolina Early Head Start/Head Start



## Well Child Check

Please email or fax this form to: [healthservices@thebjec.org](mailto:healthservices@thebjec.org)

Fax: 843-589-1197

Child's Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Gender: \_\_\_\_\_ Center: \_\_\_\_\_

SCDHEC IMMUNIZATION CERTIFICATE IS REQUIRED. Next imm. appt. \_\_\_\_\_

Check Appropriate Well Child Assessment Date of Exam: \_\_\_\_\_

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) 1<sup>st</sup> \_\_\_\_\_ Results: \_\_\_\_\_ 2<sup>nd</sup> \_\_\_\_\_ Results: \_\_\_\_\_

### Sensory Screenings

**Ages 0-3**

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

Vision:  Normal  Abnormal

Vision: Right eye \_\_\_\_\_ Left eye \_\_\_\_\_

Hearing:  Normal  Abnormal

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 Rx needed)

Medication during Head Start hours: (Separate Form)	List Med(s):	Dosage	Frequency	<input type="checkbox"/> <u>No</u> Meds during Head Start hours  <input type="checkbox"/> Physician authorizes child <u>may</u> 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: \_\_\_\_\_ Return Fax # 843-589-1197

PARENT'S SIGNATURE

