



## Part II – Health Evaluation

**To the Health Care Provider: Please complete all sections and sign. Explain any screenings required by age but not conducted.**

Child's Name \_\_\_\_\_
Birth Date (mm/dd/yy) \_\_\_\_\_
Date of History/Physical Exam (mm/dd/yy) \_\_\_\_\_

LENGTH/HEIGHT		WEIGHT		WT FOR HT/BMI	HEAD CIRCUMFERENCE <sup>1</sup>		BLOOD PRESSURE <sup>2</sup>
IN/CM	%ILE	LB/KG	%ILE	%ILE	IN/CM	%ILE	/

Screening/Test Results				Immunization Record									
Screening Test	Result	Date	Abnormal/Comments	Vaccine (Month/Day/Year)									
<b>Vision<sup>2</sup></b> Test type: _____				Dose 1	Dose 2	Dose 3	Dose 4	Dose 5	Dose 6				
<b>Hearing<sup>3</sup></b> Test type: _____				<b>DTP</b>									
<b>Lead<sup>4</sup></b> Risk: Yes/No				<b>DTP/Hib</b>									
<b>TB<sup>4</sup></b> Risk: Yes/No				<b>DTaP</b>									
<b>Urinalysis (UA)<sup>4</sup></b>				<b>DT/Td</b>									
<b>Anemia<sup>5</sup></b> (HGB/HCT) Risk: Yes/No				<b>OPV</b>									
<b>Developmental Assessment<sup>6</sup></b> Test type: _____				<b>IPV</b>									
<b>Has this child received dental care in the last 12 months?<sup>7</sup></b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A				<b>MMR</b>									
<b>* Chronic Disease Assessment:</b> Yes No <span style="float: right;">Date of onset</span>				<b>Measles</b>									
<input type="checkbox"/> <input type="checkbox"/> Asthma: <input type="checkbox"/> mild <input type="checkbox"/> moderate <input type="checkbox"/> severe <input type="checkbox"/> exercise induced <input type="checkbox"/> unclassified				<b>Mumps</b>									
<input type="checkbox"/> <input type="checkbox"/> Diabetes: <input type="checkbox"/> Type I <input type="checkbox"/> Type II				<b>Rubella</b>									
<input type="checkbox"/> <input type="checkbox"/> Anaphylaxis: <input type="checkbox"/> med. <input type="checkbox"/> food <input type="checkbox"/> insect <input type="checkbox"/> latex				<b>HIB</b>									
<input type="checkbox"/> <input type="checkbox"/> Seizures: Type _____				<b>Hep B</b>									
<input type="checkbox"/> <input type="checkbox"/> Other: Please specify _____				<b>Varicella</b>									
<b>Minimum requirements:</b> <sup>1</sup> Up to 2 years; <sup>2</sup> annual at 3 years; <sup>3</sup> annual at 4 years; <sup>4</sup> as needed; <sup>5</sup> 9–12 months; <sup>6</sup> each visit through 5 years; <sup>7</sup> annual at 2–3 years. <b>Federal requirements (eg, Head Start, WIC) may vary.</b> <b>*Prior to Public School Entry: Same as above and Hgb/hct.</b>				<b>PCV</b>									Pneumococcal conjugate vaccine
				<b>Other Vaccines (Specify)</b>									
				<b>Disease Hx of above</b> _____ (Specify) (Date mm/yy) (Confirmed by)									
				<b>Exemption</b>									
				Religious _____ Medical: Permanent _____ Temporary _____ Date _____									
				Recertify Date _____ Recertify Date _____ Recertify Date _____									

This child has the following problems which may adversely affect his or her educational experience:

Vision     Auditory     Speech/Language     Physical Dysfunction     Emotional/Social     Behavior  
 The child has a health condition which may require intervention at the program, e.g., seizures, allergies, asthma, anaphylaxis, special diet, long-term medication. *Specify:* \_\_\_\_\_

- Yes  No This child has a medical or emotional illness/disorder that now poses a risk to other children or affects the child's ability to participate safely in the program.
- Yes  No Based on this comprehensive history and physical examination, this child has maintained his/her level of wellness.
- The child may fully participate in the program.
- The child may fully participate in the program with the following restrictions/adaptation: (Specify reason and restriction.) \_\_\_\_\_

I would like to discuss information in this report with the early childhood provider and/or health consultant/coordinator.

Signature of health care provider	MD/DO NP PA	Name (Please type or print.)	Phone number
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Address: \_\_\_\_\_

<input type="checkbox"/> Yes <input type="checkbox"/> No Is this the child's Medical Home?	Next Appointment (mm/yy): _____	Next Immunization Appointment (mm/yy): _____
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