

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 ¹		BLOOD PRESSURE ²
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)												
Vision² Test type: _____				Dose 1	Dose 2	Dose 3	Dose 4	Dose 5	Dose 6							
Hearing³ Test type: _____				DTP												
Lead⁴ Risk: Yes/No				DTP/Hib												
TB⁴ Risk: Yes/No				DTaP												
Urinalysis (UA)⁴				DT/Td												
Anemia⁵ (HGB/HCT) Risk: Yes/No				OPV												
Developmental Assessment⁶ Test type: _____				IPV												
Has this child received dental care in the last 12 months?⁷ <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A				MMR												
* Chronic Disease Assessment: Yes No Date of onset <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 _____ <input type="checkbox"/> <input type="checkbox"/> Diabetes: <input type="checkbox"/> Type I <input type="checkbox"/> Type II _____ <input type="checkbox"/> <input type="checkbox"/> Anaphylaxis: <input type="checkbox"/> med. <input type="checkbox"/> food <input type="checkbox"/> insect <input type="checkbox"/> latex _____ <input type="checkbox"/> <input type="checkbox"/> Seizures: Type _____ <input type="checkbox"/> <input type="checkbox"/> Other: Please specify _____				Measles												
Minimum requirements: ¹ Up to 2 years; ² annual at 3 years; ³ annual at 4 years; ⁴ as needed; ⁵ 9–12 months; ⁶ each visit through 5 years; ⁷ annual at 2–3 years. Federal requirements (eg, Head Start, WIC) may vary. *Prior to Public School Entry: Same as above and Hgb/hct.				Mumps												
				Rubella												
				HIB												
				Hep B												
				Varicella												
				PCV											Pneumococcal conjugate vaccine	
				Other Vaccines (Specify)												
				Disease Hx of above												
				(Specify)			(Date mm/yy)		(Confirmed by)							
				Exemption												
				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: _____

Yes No Is this the child's Medical Home? Next Appointment (mm/yy): _____ Next Immunization Appointment (mm/yy): _____