Head Start *and* Inspire Kids

Child Well Care Medical Report

This form follows AAP recommendations for Well Care Visits and NYS Health Dept. EPSDT Guidelines. *Rev June 2019*

Part 1: Child's Personal Information:

Child Name:	Date of Birth:	Parent/Guardian Name:

Part 2: Child's Health History, Examination, Results and Recommendations. (Please provide screening and testing results)

Date of Exam:	BP ☐ Nml ☐ Abnl	Hct/Hct Result: ☐ Nml ☐ Abnl	Height: Weight: ☐ Nml ☐ Abnl	Did the child see a Dentist in last year? ☐Yes ☐No ☐ferred

Health Concerns:		Referred or Treated	Health Concerns:		Referred or Treated
Dental-Oral Health	☐None ☐Yes	☐Referred ☐Under RX	Language	☐None ☐Yes	☐Referred ☐Under RX
Asthma	☐None ☐Yes	☐Referred ☐Under RX	Speech	☐None ☐Yes	☐Referred ☐Under RX
Development	☐None ☐Yes	☐Referred ☐Under RX	Vision	☐None ☐Yes	☐Referred ☐Under RX
Behavorial/Emotional	☐None ☐Yes	☐Referred ☐Under RX	Hearing	☐None ☐Yes	☐Referred ☐Under RX
Learning/Attention	☐None ☐Yes	☐Referred ☐Under RX	Neurologic	☐None ☐Yes	☐Referred ☐Under RX

A. Significant health history, conditions, communicable illness or restrictions that may affect participation at school or play?

☐None ☐ Yes, please detail:

B. Significant allergies or health conditions that may require medication, special treatment, accomodations or emergency care at school?

☐None ☐ Yes, please detail: (Medication at school requires a separate consent and instructions from both the doctor and parent.)

C. Participation in Daily Activities: Diet and Activity Restrictions require a statement of condition and duration.

Can child have a Regular Diet at school, including milk? ☐ Yes ☐ No, please detail:

(for Milk Allergies, HS uses Rice Milk)

Can child participate in daily outdoor activities and gym exercise? ☐ Yes ☐ No, please detail:

Part 3: Tuberculosis and Lead Exposure Risk Assessment and Testing

TB Exposure Risk?	☐ High ☐ Low	PPD Test Date:	☐ Negative ☐ Positive	☐ CXR Negative ☐ CXR Positive	☐ **Treated**

Lead Exposure Risk?	☐ High ☐ Low	Lead Test Date:	Result at 2 yrs old:	☐ Treated ☐ Must be Monitored

Part 4: Required Provider Certification and Signature

On the basis of my findings, indicated above, and knowledge of the above named child, I find that: (s)he is free from contagious and communicable disease and is able to participate in school and day care ☐ **Yes** ☐ **No.**

Signature of Examiner

Address, City, State, Zip

Name (Please Print) and Title

( ) Phone Number

Date:

Part 5: Immunization Information (please fill in or attach copy of immunization record)

Diptheria-Tetanus-Pertussis	1st	2nd	3rd	4th	5th
Hemophilus Influenzae B (HIB)	1st	2nd	3rd	4th	
Hepatitis B (HBV)	1st	2nd	3rd		
Polio	1st	2nd	3rd	4th	
Measles-Mumps-Rubella (MMR)	1st	2nd			
Varicella/Chicken Pox	1st	2nd			
Pneumococcal Conjugate (PCV)	1st	2nd	3rd	4th	
Other	1st	2nd	3rd	4th	

Note: Those children who have received at least one dose of each required vaccine and have an appointment schedule to receive the remainder of the required doses are considered in process of receiving the required vaccines and may remain in the program as long as the appointment schedule is kept and the parent provides verification the vacines have been administered.

FOR DOCTORS ONLY

Medical Exemption:

The physical condition of the child is such that one or more of the following immunizations would endanger life or health:

_____

_____ _____

Signature of Doctor/Medical Provider Date