

Child's Name: _____

DOB ____/____/____

SCREENING TESTS AND RESULTS (See Schedule)

SCREENING TESTS	DATE DONE	RESULTS																								
Hematocrit or Hemoglobin		Hct. % Hb gms %																								
Newborn Screening or Hemoglobin Electrophoresis																										
Lead Risk Assessment																										
Lead Screening (Venous preferred)																										
Tuberculin Screening (PPD Mantoux)*																										
Vision Screening		NL AB Red Reflex <input type="checkbox"/> <input type="checkbox"/> Cover Test <input type="checkbox"/> <input type="checkbox"/>																								
Note: Screening for Amblyopia requires separate distance acuity measurements in each eye and a fusion test. (ages 3-6 yrs)		<table border="0"> <tr> <td></td> <td></td> <td>FAR</td> <td></td> <td>NEAR</td> <td></td> </tr> <tr> <td>Right</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>Left</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>Both</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> </table>			FAR		NEAR		Right	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Left	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Both	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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Both	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																					
Hearing Screening																										
OTHER TESTS (Specify)																										

* Not required at entry or for all children.

	DATE IMMUNIZATION GIVEN				
	1st	2nd	3rd	4th	5th
Hep B					
DTaP					
Polio					
Hib					
PCV Pneumococcal					
MMR					
Varicella					
Hep A					
Influenza yearly 6-59 mos.					
Rotavirus					
Other					

DENTAL ASSESSMENT Date: ____/____/____

1. Examiner MD DDS Dental Hygienist
 Other Health Care Professional (Specify) _____

2. Does the child sleep with a bottle? Yes No

3. Findings

A. No Visible Problems
(Clean mouth, no visible cavities, healthy gums)

B. Some Problems Detected
(Cavities, inflamed gums, open bite, malocclusion)

C. Severe Problems
(Baby bottle tooth decay; extensive cavities; abscesses)

D. Other (Specify):

Referral Suggested if B, C or D is checked

4. Has the child been referred to Dentist? Yes No

NUTRITIONAL UPDATE

Up to age 1 year: Is the child on?

Formula? No Yes

Breast milk? No Yes

Solid foods? No Yes

1 year and above:

Is child bottle fed? No Yes

Type of diet? _____

Unusual dietary habits? No Yes, specify _____

Dietary restrictions? No Yes, specify _____

DIAGNOSES/PROBLEMS/CLINICAL IMPRESSIONS

(Include all chronic conditions or conditions/findings needing follow-up)

1. _____

2. _____

3. _____

4. _____

5. _____

PLAN (Therapies, Referrals, F/U)

1. Next Appointment Date ____/____/____

2. Follow-up Needed Yes No
(Specify referral and date) _____

3. _____

4. _____

5. _____

RECOMMENDATIONS

1. Approve participation in early childhood program/day care? Yes No

2. Special recommendations for child? Specify treatments provided, or recommended evaluations. Does child require special education or early intervention? _____

Signature _____ Date of Exam. _____

Name (PLEASE PRINT) _____ Degree: _____

License No. _____ Telephone No. _____

Address _____

Name/Address Stamp, if available: