SLHDA/HEAD START
CHILD HEALTH ASSESSMENT REPORT

Child: ______________________________ ***DOB:*** ___/____/____

Center: ____________________________ □ ***COPA***

Relevant Health/Medical History: ____

Allergies: _________________________________ Medications: _______________________________

Date of well-exam: _____________ Height: ______Weight: _______Overweight □ Yes or □ No B/P: _________

Physical Examination	□ Normal	If Abnormal--Comments
Head/Ears/Eyes/Nose/Throat		
Teeth		
Cardiorespiratory		
Abdomen/GI		
Genitalia/Breasts		
Extremeties/Joints/Back/Chest		
Skin/Lymph Nodes		
Neurologic/Developmental		

Immunizations	Date #1	Date #2	Date #3	Date #4	Date #5
Polio					
DTAP/DTaP					
MMR					
HIB					
Hepatitis B					
Varicella					
Hepatitis A					
Pneumococcal					
Rotovirus					

Head Start requires all children be up to date with all EPSDT requirements. Please complete blood lead testing if child was not tested at 1 year 9 months or later. Testing at age 1 does not meet PA EPSDT standards.

Screening Tests	Test Date	Result
Lead (1yr 9 mos or >)		
Hgb/Hct		
Hearing (Objective)		
Vision (Objective)		

HEALTH PROBLEMS OR SPECIAL NEEDS, RECOMMENDED TREATMENT/SPECIAL CARE:

Medical Care Provider:_____________________________ Signature: ______________________

Address: Date: ______________________

HCP Fax: ______________________

Phone Number: Head Start Fax: ______________________