EPSDT / SCREENINGS / PHYSICAL EXAMINATION / ASSESSMENT
EARLY CHILDHOOD FORM *AGE 15 MONTHS THROUGH 5 YEARS*

CHILD'S NAME:	**SEX:**	**BIRTHDATE:**
PARENT/GUARDIAN NAME AND ADDRESS:		**PHONE:**
HEAD START CENTER NAME AND ADDRESS:	**C-L-M Community Action Agency** **Head Start/Early Head Start/ Preschool Program** **P.O. Box 70 524 Ashmun Street** **Sault Ste. Marie, Mi 49783**	
Phone: (906) 632-3363 **Fax : (906) 632-4255**		

PART I: To be completed before and during Physical Examination/Assessment

1. RELEVANT HISTORY AND ADDITIONAL INFORMATION ***(from Health History, Parent/Teacher Observations. Also enter Primary Physician name and address if form will be sent to a different provider)***

2. SCREENING TESTS: ***All items are required by Head Start and recommended by the American Academy of Pediatrics for age 15 Months through 5 Year well child visits. At a minimum, check appropriate boxes in RESULTS/DATE column. Enter date if done previously. Provide comments on: services needed, suspect or atypical results and reasons services were not performed.***

TEST	RESULTS / DATE	COMMENTS
A. Present Age	**Yrs. Mos.**	**Well Child:** ☐15mo ☐18mo ☐24mo ☐30 mo **Visit Age:** ☐3Yr ☐4Yr ☐ 5Yr
B. Immunization Review	☐**Up to date** ☐**Immunizations Needed** ☐**Review Not Performed**	Immunizations given today:
C. History	☐**Performed** ☐**Not Performed**	
D. Blood Pressure ***(Perform at 3 Yr. and 4Yr.)***	☐**Normal** ☐**Suspect** ☐**Atypical** ☐**Not Performed**	
E. Height _____ Weight _____ ***(No shoes, to nearest 1/8 in.)***	☐**Normal** ☐**Suspect** ☐**Atypical** ☐**Not Performed**	
F. Hearing ***(Test at Each Visit - Must be Objective Test at 3 Yr., 4 Yr and 5 Yr.)***	☐**Normal** ☐**Suspect** ☐**Atypical** ☐**Not Performed**	
G. Vision	☐**Normal** ☐**Suspect** ☐**Atypical** ☐**Not Performed**	
H. Developmental Assessment (Autism Screen 18 & 24 months)	☐**Normal** ☐**Suspect** ☐**Atypical** ☐**Not Performed**	
I. Dental Inspection	☐**Normal** ☐**Suspect** ☐**Atypical** ☐**Not Performed**	
J. Blood Lead ***(Perform at 24*** Mo. If never tested, perform between 3 Yr. and 5 Yr.) ***Results*** _____	☐**Normal** ☐**Suspect** ☐**Atypical** ☐**Not Performed**	
K. Hematocrit or Hemoglobin ***(not required at 5 Yr)*** **Hct._____ Hgb._____**	☐**Normal** ☐**Suspect** ☐**Atypical** ☐**Not Performed**	
L. Cholesterol ***(Test High Risk child at 24 Mo., 3 Yr. and 4 Yr.)*** ☐ **High Risk** ☐ **Low Risk**	☐**Normal** ☐**Suspect** ☐**Atypical** ☐**Not Performed**	
M. Sickle Cell[1] ***(Perform once between 6 Mo. and 20 Yr.)***	☐**Normal** ☐**Suspect** ☐**Atypical** ☐**Not Performed**	
N. Nutritional Assessment	☐**Normal** ☐**Suspect** ☐**Atypical** ☐**Not Performed**	
O. Tuberculin (TB) Test[2] ***(Perform if High Risk)*** ☐ **High Risk** ☐ **Low Risk**	☐**Normal** ☐**Suspect** ☐**Atypical** ☐**Not Performed**	
P. Interpretive Conference	☐**Performed** ☐**Not Performed**	
Q. Anticipatory Guidance	☐**Performed** ☐**Not Performed**	
R. Injury Prevention	☐**Performed** ☐**Not Performed**	

1. The test should have been performed on children born in a Michigan hospital on or after 10/1/97. For other children with all or some black heritage, the test is required prior to the child's 21st birthday unless electrophoresis for sickle cell was done when the child was at least 6 months of age and the results are known to the parent.
2. Testing should be done upon recognition of high risk factors. If results are negative but high risk situation continues, testing should be repeated on an annual basis.

PART II: To be completed by Health Care Provider During and After Physical Examination/Assessment

3. PHYSICAL EXAMINATION / ASSESSMENT: *All items are required by Head Start and recommended by the American Academy of Pediatrics for children age 15 months through 4 years. Please check appropriate columns (Normal for Age; Atypical; or Not Evaluated) and provide comments on: services needed, atypical results/scores; behavior/mental health problems and reasons for items not evaluated.*

	Normal for Age	Atypical	Not Evaluated	COMMENTS *(Use additional sheets if necessary.)*
A. General Appearance				
B. Posture, Gait				
C. Speech				
D. Head				
E. Skin				
F. Eyes:				
(1) External Aspects				
(2) Optic Fundiscopic				
(3) Cover Test				
G. Ears:				
(1) External & Canals				
(2) Tympanic Membranes				
H. Nose, Mouth, Pharynx				
I. Teeth				
J. Heart				
K. Lungs				
L. Abdomen *(include hernia)*				
M. Genitalia				
N. Bones, Joints, Muscles				
O. Neurological / Social				
(1) Gross Motor				
(2) Fine Motor				
(3) Communication Skills				
(4) Cognitive				
(5) Self-Help Skills				
(6) Social Skills				
P. Glands *(Lymphatic/Thyroid)*				
Q. Muscular Coordination				
R. Other				

S. General Statement on Child's Medical Status (Please note any allergies):

Should the child's activity be restricted due to physical defect or illness? ☐Yes ☐No If yes, check below and explain degree of restriction:

☐Classroom ☐Playground ☐Gym ☐Swimming ☐Sports ☐Camp ☐Other

4. FINDINGS, TREATMENTS AND RECOMMENDATIONS

ABNORMAL FINDINGS / DIAGNOSIS	TREATMENT PLAN	RECOMMENDED FOLLOW-UP OR RESULTS	DATE

PHYSICIAN NAME AND ADDRESS (PLEASE PRINT): **PHONE:**

FAX:

Signature **Date**