EPSDT / SCREENINGS / PHYSICAL EXAMINATION / ASSESSMENT
INFANT FORM — AGE ONE MONTH THROUGH 12 MONTHS

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/GSRP, 524 Ashmun Street, Sault Ste. Marie, MI 49783		
Phone: (906) 632-3363 Fax: (906) 632-4255		

PART I: To be completed before 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 one month through 12 month 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 Visit Age: ☐1mo ☐2mo ☐4mo ☐6mo ☐9mo ☐12mo
B. Immunization Review	☐Up to date ☐Immunizations Needed ☐Review Not Performed	Immunizations given today:
C. History	☐Performed ☐Not Performed	
D. Height _____ Weight _____ *(No shoes, to nearest 1/8 in.)*	☐Normal ☐Suspect ☐Atypical ☐Not Performed	
E. Hearing	☐Normal ☐Suspect ☐Atypical ☐Not Performed	
F. Vision	☐Normal ☐Suspect ☐Atypical ☐Not Performed	
G. Developmental Assessment	☐Normal ☐Suspect ☐Atypical ☐Not Performed	
H. Dental Inspection	☐Normal ☐Suspect ☐Atypical ☐Not Performed	
I. Blood Lead *(12 Mo. only)* *Results*_____	☐Normal ☐Suspect ☐Atypical ☐Not Performed	
J. Hematocrit or Hemoglobin Hct._____ *(Perform once between 1 Mo. and 12 Mo.)* Hgb._____	☐Normal ☐Suspect ☐Atypical ☐Not Performed	
K. Sickle Cell[1] *(Perform once between 6 Mo. and 20 Yr.)*	☐Normal ☐Suspect ☐Atypical ☐Not Performed	
L. Nutritional Assessment	☐Normal ☐Suspect ☐Atypical ☐Not Performed	
M. Tuberculin (TB) Test[2] ☐ High Risk ☐ Low Risk *(12 Mo. if High Risk)*	☐Normal ☐Suspect ☐Atypical ☐Not Performed	
N. Interpretive Conference	☐Performed ☐Not Performed	
O. Anticipatory Guidance	☐Performed ☐Not Performed	
P. Injury Prevention	☐Performed ☐Not Performed	

1. The test should have been performed on children born in a Michigan hospital on or after 10/1/87. 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 one month through 12 months. 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 Fundoscopic				
(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:**

Signature **Date**