Mid America Head Start: HEALTH RECORD (3 thru 5 YEARS)

NAME: _____ **DOB:** _____ **SEX:** ____ **AGE:** ____
RACE/ETHNICITY: _____ **DATE of EXAM:** _____

FAMILY PROFILE AND HEALTH ___ No change in household since last visit
Child lives with: ____Mother ____Father ____Stepparent ___Grandparent ___Other Total adults living in home: ____
Total children living in home: ____ Primary caretaker for this child: _____ Relationship: _____
Family's concerns/problems:

NUTRITION *Problems: special diet, inappropriate weight gain, anemic, lead poisoning, chronic GI problems, major food allergies, refusal of any food group, developmental __Y __N
Usual Servings Per Day: ___Dairy __Vegetables WIC _Y _N
__Breads, cereal, rice and pasta ___Meat, poultry, fish, eggs and dry beans ___Fruits
*If answered yes, further assessment needed Fluoride: __Y __N Supplement: __Y __N

DEVELOPMENT Parent's concerns

3 YEARS
_Brushes teeth with help
_Tower of 6 cups
_Uses pronouns, I, you, me
_Throws ball overhand

4 YEARS
_Puts on T-shirt
_Wiggles thumb
_Expresses needs, ideas in 3-6 word sentence
_Balances on 1 foot, 2 sec

5 YEARS
_Brush teeth-no help
_Copies
_Carries on a conversation
_Balances on 1 foot, 3 sec

Standardized screen: __P __F __Not Done
Further assessment needed: __Yes __No
Vision Screen: __Normal __Abnormal
Hearing Screen: __Normal __Abnormal

CHILD HEALTH: Does the systems review note any problems or parent concerns: __Yes ___No Explain:
Major illnesses, injury hospitalization, surgery (since last visit):

Allergies:
Medication taken regularly, Type/Reason:
Dental Care:
Mental Health/Behavioral Concerns:

PHYSICAL EXAMINATION

HGB/HCT_____ **LEAD**_____
BP _____ **Height**_____ (%)_____ **Weight** _____ (%)_____
Temp _____ Pulse _____ Resp _____

N	A	NE	
☐	☐	☐	Appearance
☐	☐	☐	Head
☐	☐	☐	Skin/nodes
☐	☐	☐	Eyes
☐	☐	☐	Ears
☐	☐	☐	Nose
☐	☐	☐	Mouth/throat
☐	☐	☐	Teeth
☐	☐	☐	Neck
☐	☐	☐	Chest/breasts
☐	☐	☐	Heart/pulses
☐	☐	☐	Lungs
☐	☐	☐	Abdomen
☐	☐	☐	Genitalia/Anus
☐	☐	☐	Spine
☐	☐	☐	Extremities
Neurologic			
☐	☐	☐	Muscle tone
☐	☐	☐	DTRs

Explain Abnormalities:

HEALTH EDUCATION
INJURY PREVENTION
__Car safety restraints
__Poisoning
__Fire Safety
__Firearms
__Street, water, bicycle Safety
__Scissors/Sharp objects
__Stranger safety
__Teach telephone Number and address
__Self-safety
__Passive smoking

BEHAVIOR
__Talk/read with child
__Exploration
__Limit television
__Discipline, consistency
__Toilet training
__Social interaction
__School readiness
__Sex education

HEALTH PROBLEMS
__Immunizations
__Well child care
__Dental care, appt.
__Family planning
__Daycare

NUTRITION
__Health diet/snacks
__Junk Food
__Iron rich foods
__Physical activity

ASSESSMENT:

PLAN

Dental referral made: __Yes __No
WIC: ___Referral ___Refused __N/A
Immunizations: __Up to date __To be given today ___Deferred
Explain:

Next appointment:

Current State of Health: I have examined the above-named child and verify that this child's medical history and current state of health ___are ____are not satisfactory for participation in a childcare program. Does this child require any specialized care? ___Yes ____No
If yes, please explain:

Name and Address of Clinic, Group, Practice or other_____

Telephone Number_____ Fax Number_____

Physician Signature _____Date _____ Physician Name (Print)_____
(This form expires one year from date of exam.)

Revised 3/14/14 Form 1090

MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
SECTION FOR CHILD CARE REGULATION

CHILD MEDICAL EXAMINATION REPORT (INFANT/TODDLER/PRE-SCHOOL)

SAV
PRIN
RESE

IDENTIFYING INFORMATION

CHILD'S NAME

BIRTHDATE

CURRENT STATE OF HEALTH

Based on my assessment of this child's medical history, current state of health and my physical examination of the child on ____ / ____ / ____ this child can participate in a child care program. This child has no special care needs unless specified below.

(Date of medical examination must be within the last 12 months.)

PHYSICIAN'S INSTRUCTIONS FOR SPECIALIZED CARE

Complete this section only if child requires special care at a child care facility, e.g. special diets, allergies, ear infections, convulsions, diabetes, asthma, behavior problems, hearing or visual impairment, etc. (Attach additional pages as needed.)

SIGNATURE OF PHYSICIAN OR REGISTERED NURSE UNDER THE SUPERVISION OF A PHYSICIAN

DATE

PHYSICIAN'S OR NURSE'S NAME (PLEASE PRINT)

NAME AND ADDRESS OF CLINIC, GROUP, PRACTICE OR OTHER (MAY USE STAMP.)

IF NURSE IS SUPERVISED BY A PHYSICIAN, INDICATE PHYSICIAN'S NAME (PLEASE PRINT.)

TELEPHONE NUMBER