Thrive by Five Detroit

STARFISH FAMILY SERVICES

Child's Name: _____ **DOB:** _____ ☐ **Male** ☐ **Female**

Parent/Legal Guardian Name: _____ **Phone (H)**_____ **Phone (C)**_____

I give permission to Head Start & my child's Health Care Provider to contact one another for medical information as needed.

Parent/Legal Guardian signature: _____

_____ **Month Well Child Exam** **Date**_____	_____ **Year Physical Exam** **Date**_____

The U.S. Dept. of Health and Human Services requires the physical examination meet the Michigan Medicaid EPSDT and requirements and MUST be completed by the healthcare provider

Please complete:

	Normal for Age	
	Yes	**No**
General Appearance		
Posture, Gait		
Skin		
Head		
Eyes/red reflex Fixes/follows with eyes		
Ears: external & inner Responds to sound		
Nose, Pharynx		
Teeth, Mouth		
Fluoride varnish applied		
Speech		
Heart & Lungs		
Abdomen		
Genitalia		
Bones, Joints, Muscles		
Neurological		
Glands		
Muscular Coordination		
Allergies (list below)		
**** Any abnormal findings above please comment below in the findings box****		

Please complete:

Required Screenings/Tests	**Results**
Height	
Weight	
BMI	
Head Circumference 1-24 months	
Blood Pressure: *3 years and older*	
Vision *3 years and older* **Date:**	☐ Normal ☐ Under care ☐ Referred ☐ Objective
Hearing *3 years and older* **Date:**	☐ Normal ☐ Under care ☐ Referred ☐ Audiometer
Hemoglobin **Date:**	**Value:** ☐ Anemia ☐ Under care
Lead **Date:**	**Value:** ☐ High Lead ☐ Under care
Sickle Cell	☐ Negative ☐ Trait ☐ Disease ☐ Under care
PPD/Tb test	
MCIR Status	

****Findings/Diagnosis/Restrictions/Chronic Conditions**
Treatment Plan/Follow-up/Referrals

This physical examination was completed according to EPSDT schedule/recommendations._____Initial

Health Care Provider Signature: _____ **Date:** _____

Phone: _____**Fax**: _____ **Address:** _____

Head Start use only

Date & initials received: _____ ☐ Entered in ChildPlus ☐ Attached in ChildPlus Final 2020