

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 _____
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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)		
<b>** Any abnormal findings above please comment below in the findings box**</b>		

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:	<input type="checkbox"/> Normal <input type="checkbox"/> Under care <input type="checkbox"/> Referred <input type="checkbox"/> Objective
Hearing 3 years and older Date:	<input type="checkbox"/> Normal <input type="checkbox"/> Under care <input type="checkbox"/> Referred <input type="checkbox"/> Audiometer
Hemoglobin Date:	<b>Value:</b> <input type="checkbox"/> Anemia <input type="checkbox"/> Under care
Lead Date:	<b>Value:</b> <input type="checkbox"/> High Lead <input type="checkbox"/> Under care
Sickle Cell	<input type="checkbox"/> Negative <input type="checkbox"/> Trait <input type="checkbox"/> Disease <input type="checkbox"/> Under care
PPD/Tb test	
MCIR Status	

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

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