Northeast Iowa Community Action-Head Start
WELL CHILD CHECK
PO Box 487 Decorah, IA 52101
Phone: 563-382-8436 Fax: 563-382-9854

Date of Well Child Check: _____

Child's Name: _____ Birthdate: _____ Current Age: _____

Screening Tests: *Starred items (*) are **required** by Head Start and **recommended** by the American Academy of Pediatrics for children 3-5 years. For **lead and hgb/hct** levels please provide **current or previous** results.*

*Height: _____ *Weight: _____ *BMI: _____ ***Blood Pressure:** *(REQUIRED)* _____

***Is this child at risk for HIGH blood LEAD levels?** □ **Yes** □ **No**
***Lead:** *(REQUIRED)* Date _____ Results _____

***Is this child at risk for LOW HEMOGLOBIN or HEMATOCRIT levels?** □ **Yes** □ **No**
***Hemoglobin/Hematocrit:** *(REQUIRED)* Date _____ Results _____

*Vision Screening: R 20/_____ L 20/_____ Glasses □ Yes □ No *Hearing Risk: □ None □ Low □ High
Tubes: □ Yes □ No

Exam Results:

N	ABN	NA	COMMENTS
			General Appearance
			Behavior/Interaction with Family
			Skin
			Head/Scalp
			Ears
			Eyes
			Nose
			Mouth/Throat
			Teeth/Oral (Was a referral made? □ Yes □ No)
			Neck
			Back/Chest
			Lungs
			Heart
			Abdomen
			Genitalia
			Musculoskeletal
			Neurologic

Allergies: □ No □ Yes _____ Prescribed Medications: □ No □ Yes _____

Health Concerns: _____

Referral: _____

□ This child may participate in a developmentally appropriate preschool with **no** health related restrictions.

□ This child may participate in a developmentally appropriate preschool **with the following restrictions**:

_____

Health Care Provider Signature: _____ MD/DO/PA/ARNP Date: _____