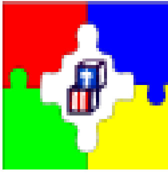

COLLEGE OF SOUTHERN IDAHO HEAD START/EARLY HEAD START
998 Washington St. N.
PO Box 1238
Twin Falls, Idaho 83303-1238
208-736-0741

Well Child Exam Form

Child's Name: ________________________________ **Date of Birth:**______________________

Please circle WCE performed today 0,2,4,6,9,12,15,18,24, 30 & 36 months Exam date:______________
At what months of age will you see this child at your practice? 0,2,4,6,9,12,15,18,24, 30 & 36 months

Height: __________ **Weight:** _______________ **Head circumference (up to 24 months)** _________

Hereditary/ Metabolic Screening (*required by 1 month of age*) **completed Y/ N Results**________________
Blood Lead Screening *(Required at 12 & 24 months)*

Blood Lead Screening Level: ______ug/dL (If ≥ 10ug/dLplease provide family education & follow up testing.)
If parents are unable to provide written documentation that their child received a blood screening for lead toxicity at ages 12 and 24 months, then CMS and Head Start requires that children receive a blood screening for lead toxicity between the ages of 36 months and 72 months.

Hermatocrit/Hemoglobin *(Required at 12 months and 24 months).* **HCT:** __________ **HG:** ___________

	NORMAL	ABNORMAL	REFERRED	NOT EVALUATED	**Comments:**
General Appearance…………………………	☐	☐	☐	☐	
Posture, Gait…………………………………	☐	☐	☐	☐	
Speech………………………………………..	☐	☐	☐	☐	
Head………………………………………….	☐	☐	☐	☐	
Skin…………………………………………..	☐	☐	☐	☐	
Eyes External Aspects………………………	☐	☐	☐	☐	
Optic Fundoscopic……………………..	☐	☐	☐	☐	
Vision Exam…………………………..	☐	☐	☐	☐	
Ears External Canal…………………………	☐	☐	☐	☐	
Hearing………………………………………	☐	☐	☐	☐	
Nose, Mouth, Throat ..………………………	☐	☐	☐	☐	
Teeth and Gums………………………………	☐	☐	☐	☐	
Heart…………………………………………	☐	☐	☐	☐	
Lungs…………………………………………	☐	☐	☐	☐	
Abdomen (Include Hernia)…………………	☐	☐	☐	☐	
Genitalia……………………………………..	☐	☐	☐	☐	
Bones, Joint, Muscles………………………..	☐	☐	☐	☐	
Glands (Lymphatic/Thyroid)………………...	☐	☐	☐	☐	
Muscular Coordination………………………	☐	☐	☐	☐	
Allergies ……………………………………..	☐	☐	☐	☐	
Developmental / Behavioral assessment……..	☐	☐	☐	☐	

Developmental Anticipatory Guidance……____
Nutritional Anticipatory Guidance…………____
Safety Anticipatory Guidance………………____
Immunizations Up to date on all Immunizations: ☐ Yes ☐ No
If no, please explain: ____

Please attach a copy of the Immunizations given today
Medications: ____

Treatment or Follow-up needed: ☐**Yes** ☐ **No** **Date of Follow-up if applicable:** _________

Date of next Well Child Exam: _________

Provider's signature______________________________ Printed or stamped Name and address of provider:

Please remember to have your provider fill in the Early Head Start Well Child Exam and Release of Information
Fax to: ___________________ **Attn:** ________________