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:** _____

Head Start Center_____ **Head Start Tracking #**_____ **Medicaid #**_____

Please circle: WCE performed today 3 yr old / 4 year old / 5 year old Exam date: _____

Hermatocrit/Hemoglobin *(Required at 5 years)* **HCT:** _____ **HG:** _____

Height: _____ **Weight:** _____ **Blood Pressure:**_____

Blood Lead Screening Level: _____ ug/dL (If ≥ 10ug/dL, please 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.**

	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

Printed or stamped Name and Address of Provider:

Provider's signature_____

H-WCE-HSFORM