Well Child Exam

(Meets EPSDT Guidelines)

Early Head Start-Head Start-ECEAP-Step Ahead

Public Health
Seattle & King County

PLEASE COMPLETE THIS FORM OR ATTACH A COPY OF THE MOST RECENT EPSDT EXAM FOR THIS CHILD.

Exam Date: _____

Please circle exam: 2 m 4 m 6 m 9 m 12 m 15 m 18 m 24 m 3 y 4 y 5 y

_____ _____ M F

Child's Name **Date of Birth** **Gender (**circle one)

Are you serving as this child's "Medical Home" or primary care provider? □ Yes □ No

Ht_____ inches Ht %_____Wt_____ lbs. Wt. %_____BMI%_____BP_____

Hematocrit/Hemoglobin*
Date: _____ Results: _____
Treatment Indicated: □ Yes □ No
Recheck Date: _____

Nutrition Concerns:
_____
_____
Is child enrolled in WIC? □ Yes □ No

Screening:

Hearing	**Hz**	**Right**	**Left**
□ Unable	4000	_____dB	_____dB
	2000	_____dB	_____dB
	1000	_____dB	_____dB

Vision	without glasses	20/_____	20/_____
□ Unable	with glasses	20/_____	20/_____

Strabismus □ No □ **Yes** □ Referral to eye care specialist

Lead screening** Lab Results:_____ Date:_____

TB screening □ Negative □ Skin positive
Chest X-ray: □ Negative □ Positive
On Medication: □ No □ Yes Start Date:_____End Date:____

Oral Health
□ no visible decay
□ visible decay or white spots
□ dental referral

Developmental Concerns: (please check if concerns and include any details under assessments/recommendations)
□ **Adaptive/Cognitive** □ **Language/Communication**
□ **Gross Motor** □ **Fine Motor**
□ **Behavior** □ **Social/Emotional** □ **None**

Allergies:
_____
_____
□ None

Current medications:
_____

Are medications needed at school? □ Yes □ No

Chronic Health Conditions:
_____
_____
□ None

Concerns/Recommendations/Follow-up:
_____
_____
_____
_____

Referrals: _____
_____
□ None

Immunizations given: (Please attach a copy of child's immunization records.) □ DTaP □ IPV □ HiB □ MMR □ PCV □ Hep B □ Varicella

*Washington State EPSDT guidelines require this lab work be done if: a) none has been done in the past 2 years; b) last test was abnormal.
**Washington State EPSDT guidelines require lead screening at ages 12 and 24 months, or between 36 and 72 months if not done previously. It is also required for children who have refugee status.

Provider Signature **Print Name** **Clinic Name** **Phone Number**

_____ _____ _____ _____

PLEASE GIVE TO PARENT/GUARDIAN TO RETURN TO HEAD START/ ECEAP AS SOON AS POSSIBLE

Fax Number: 206-767-4997 **Phone Number: 206-767-6896**