

SCREENING TESTS AND RESULTS (See Schedule)

SCREENING TESTS	DATE DONE	RESULTS
Hematocrit or Hemoglobin		Hct. % Hb gms %
Newborn Screening or Hemoglobin Electrophoresis		
Lead Risk Assessment		
Lead Screening (Venous preferred)		
Tuberculin Screening (PPD Mantoux)*		
Vision Screening		NL AB Red Reflex <input type="checkbox"/> <input type="checkbox"/> Cover Test <input type="checkbox"/> <input type="checkbox"/>
Hearing Screening		
OTHER TESTS (Specify)		

* See recommended schedule: Not required at entry or for all children.

DENTAL ASSESSMENT Date: ____/____/____

- Examiner MD DDS Dental Hygienist
 Other Health Care Professional (Specify) _____
 - Does the child sleep with a bottle? Yes No
 - Findings
 - A. No Visible Problems
(Clean mouth, no visible cavities, healthy gums)
 - B. Some Problems Detected
(Cavities, inflamed gums, open bite, malocclusion)
 - C. Severe Problems
(Baby bottle tooth decay; extensive cavities; abscesses)
 - D. Other (Specify):
- Referral Suggested if B, C or D is checked
- Has the child been referred to Dentist? Yes No

NUTRITIONAL UPDATE

- Up to age 1 year: Is the child on?
- Formula? No Yes
- Breast milk? No Yes
- Solid foods? No Yes
- 1 year and above:
- Is child bottle fed? No Yes
- Type of diet? _____
- Unusual dietary habits? No Yes, specify _____
- Dietary restrictions? No Yes, specify _____

	DATE IMMUNIZATION GIVEN				
	1st	2nd	3rd	4th	5th
DTP					
DT					
DTaP					
Hb					
OPV/IPV					
Hep B					
MMR					
Varicella					
Pneumococcal					

DIAGNOSES/PROBLEMS/CLINICAL IMPRESSIONS

- (Include all chronic conditions or conditions/findings needing follow-up)
- _____
 - _____
 - _____
 - _____
 - _____

PLAN (Therapies, Referrals, FIU)

- Next Appointment Date ____/____/____
- Follow-up Needed Yes No
(Specify referral and date) _____
- _____
- _____
- _____

RECOMMENDATIONS

- Approve participation in early childhood program/day care? Yes No
- Special recommendations for child? Specify treatments provided, or recommended evaluations. Does child require special education or early intervention?

Name/Address Stamp, if available:

Signature _____ Date of Exam. _____

Name (PLEASE PRINT) _____ Degree: _____

License No. _____ Telephone No. _____

Address _____