**Physician**

**It is the policy of Floyd County Head Start that any child enrolled in our program must have a completed Well Child Check-Up and the following tests/exams:**

* All items are required by Head Start and recommended by the American Academy of Pediatrics for ages one month through 5 years of age on well child visits. At a minimum, mark appropriate boxes on the assessment section. The screening section enter the date and results for testing competed.
* Proof of Immunizations- **Attach an updated Shot Record.** The child cannot attend school without proof of immunizations. If a child is behind on his/her immunizations, we must have a statement indicating catch-up is in process.
* If the parent does not have Medicaid/HHW or health insurance, they need to contact Head Starts Health Office for assistance. The Health Office phone number is 948-6981 ext 1104 (Mary), ext 1111 (Rene) or ext 1216 (Cortney). The fax number is 812-948-6989.

**FLOYD COUNTY HEAD START FORMULARIO DE EXAMEN DE SALUD**

Estimados Padres o Tutores,

* Los niños deben tener un examen actual de niño sano en el archivo en todo momento. Debe reportar todas las citas a la Oficina de Salud.
* Si su hijo tuvo un examen de niño sano recientemente, NO hay necesidad de repetir el examen. Puede llevar este formulario al médico para que lo complete y devolverlo.
* Ofrecemos asistencia financiera si su hijo no tiene Medicaid / HHW o seguro médico. Por favor, póngase en contacto con la oficina de salud.
* Si su hijo no tiene un médico, a continuación se enumeran aquellos que colaboran con Head

Start.

Growing Kids Pediatrics 3321 Ballard Ln, New Albany (812) 944-4575

All In Pediatrics 2305 Green Valley Rd., New Albany (812) 949-0405

Complete Pediatrics 223 E. Spring St, New Albany (812) 945-2229

Bichir, MD, Adel 1915 West St. Suite B, New Albany (812) 945-5246

Jeffersonville Pediatrics 207 Spark Ave. Suite 403, Jeffersonville (812) 288-9141

\*Norton CMA 2051 Clevidence Blvd. Suite C, Clarksville (812) 280-6623

\*Norton CMA 3118 East 10th St. Suite A, Jeffersonville (812) 282-6979

\* Hablan español

Si tiene alguna pregunta, puede llamar a la Oficina de Salud y hablar con el Gerente de Salud o el Asistente de Salud. El número de teléfono de la Oficina de Salud es 948-6981, extensión 1112. El número de fax de la Oficina de Salud es 812-948-6989 .

**Por favor llene esta casilla para su registro**.

El doctor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Teléfono #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cita de chequeo de niño sano: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Floyd County Head Start Well Child Check-Up**

Date of Exam: \_\_\_\_\_/ \_\_\_\_\_\_\_/ \_\_\_\_\_\_\_\_\_ ***Please attach updated SHOT RECORD and fax completed exam to 812-948-6989***

Child’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Child’s Age\_\_\_\_\_\_Yrs.\_\_\_\_\_\_\_Mos.

|  |  |  |  |
| --- | --- | --- | --- |
| **Physical Exam/Assessment** | **WNL** | **Abnormal** | **Not Evaluated** |
| General Appearance |  |  |  |
| Posture, Gait |  |  |  |
| Speech |  |  |  |
| Head |  |  |  |
| Skin |  |  |  |
| Eyes |  |  |  |
| Ears |  |  |  |
| Nose, Mouth, Pharynx |  |  |  |
| Teeth (Dental Screening 0-2yrs) |  |  |  |
| Heart |  |  |  |
| Lungs (include asthma & reactive airway) |  |  |  |
| Abdomen |  |  |  |
| Genitalia |  |  |  |
| Bones. Joints, Muscles |  |  |  |
| Neurological/Social |  |  |  |
| Glands (Lymphatic/Thyroid) |  |  |  |
| Muscular Coordination |  |  |  |
| Other |  |  |  |

**Physicians please answer the questions below:**

**Does the child have any health conditions that would be hazardous either to him/her or to the other children in a group setting as a result of participating in normal activities, including sports?**

YES NO

If yes, what modification of normal activities would be necessary to protect the child or the classmates? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Have you prescribed any medications or special routines which should be included in the Head Start plans for the child’s activities?**

YES NO

If yes, please explain­­­­­­­­ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Is this child up to date on a scheduled of well child care, including immunizations?**  YES NO

|  |  |  |
| --- | --- | --- |
| **Screening Test** | **Date** | **Result** |
| **Height**  (No shoes and to the nearest ¼) |  |  |
| **Weight**  (To the nearest ¼) |  |  |
| **Head Circumference**  Perform at each visit up to 24 mos. |  |  |
| **Blood Pressure**  Perform at 3yrs-5yrs |  |  |
| **Hearing-**  **Perform at each well visit between 0-3 years subjective and 3+ yrs. objective** |  | WNL  Abnormal |
| **Vision-**  **Perform at each well visit between 0-3 years subjective and 3+ yrs. objective** |  | WNL Abnormal  Acuity: Left\_\_\_\_\_\_\_\_\_  Right\_\_\_\_\_\_\_\_ |
| **Hemoglobin-(MOST RECENT)**  Perform at 9mos and at 24 mos.  If never tested, perform at 2+ yrs. |  |  |
| **Lead-(MOST RECENT)**  Perform at 12 mos. and at 24 mos.  If never tested, perform at 2+yrs |  |  |
| **Cholesterol-**  Test High risk child at 24 mos., 3yrs and 5 yrs**.** |  | Low Risk  Results\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Sickle Cell-**  Performed as newborn screening |  |  |
| **Tuberculin TB Testing**  **High Risk Only** |  | Low Risk  Results\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Anticipatory Guidance:**  **Violence Prevention, Injury Prevention, Safe Sleep and/or nutritional counseling** |  | Performed  Not Performed |

|  |
| --- |
| Comments on Mental Health or Behavioral Concerns:  Comments/Recommendations/Referrals:  Next Scheduled Appointment Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

Physician’s Printed Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Physician’s Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_