

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"/>
Note: Screening for Amblyopia requires separate distance acuity measurements in each eye and a fusion test. (ages 3-6 yrs)	FAR NEAR Right <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Left <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> PF Both <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
Hearing Screening		
OTHER TESTS (Specify)		

* Not required at entry or for all children.

	DATE IMMUNIZATION GIVEN				
	1st	2nd	3rd	4th	5th
Hep B					
DTaP					
Polio					
Hib					
PCV Pneumococcal					
MMR					
Varicella					
Hep A					
Influenza yearly 6-59 mos.					
Rotavirus					
Other					

DENTAL ASSESSMENT Date: ____/____/____

1. Examiner MD DDS Dental Hygienist
 Other Health Care Professional (Specify) _____

2. Does the child sleep with a bottle? Yes No

3. 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

4. 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 _____

DIAGNOSES/PROBLEMS/CLINICAL IMPRESSIONS
(Include all chronic conditions or conditions/findings needing follow-up)

1. _____

2. _____

3. _____

4. _____

5. _____

PLAN (Therapies, Referrals, F/U)

1. Next Appointment Date ____/____/____

2. Follow-up Needed Yes No
(Specify referral and date) _____

3. _____

4. _____

5. _____

RECOMMENDATIONS

1. Approve participation in early childhood program/day care? Yes No

2. 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 _____