Head Start Well-Child Exam
Infant, toddler, pre-school

Return to: MVAC Head Start – Health
706 N. Victory Dr.
Mankato, MN 56001
Fax: (507) 345-2429
Phone: (507) 345-2468
Email: hsfax@mnvac.org

Child's Name: _____

Date of Birth: _____ ☐ Male; ☐ Female **Date of Examination:** _____

Well child exam for Age: ☐ 0-1 mo; ☐ 2-mo; ☐ 4-mo; ☐ 6-mo; ☐ 9-mo; ☐ 12-mo; ☐ 15-mo; ☐ 18-mo; ☐ 24-mo; ☐ 30-mo; ☐ 3-yr; ☐ 4-yr; ☐ 5yr;

Height _____; **Weight**_____; **BMI Percentile** (≥ 24 mo.) _____; **Blood Pressure** (≥ 3 years) _____

Head Circumference (≤ 24 mo.) _____; **Weight for length percentile** (≤ 2-yrs.) _____

Exam Results

	N	Ab	***(describe abnormal results)***
HE ENT			
Heart			
Lungs			
Stomach/Abdomen			
Genitalia			
Extremities, Joints, Muscles, Spine			
Skin, Lymph Nodes			
Neurological			

Laboratory Test/Risk Assessment

Lead *from today or a past result*	Record Value:	Date:
Hgb/Hct (*between **9 & 15 mo***)	Record Value:	Date:

☐ **Newborn Screening Follow-up** **TB Risk Assess**
☐ **Dyslipidemia Risk Assessment** *(24 m. & 4 yr.)*
Describe any abnormal result - follow-up needed

Developmental, Social/Emotional, Mental Health

Results of any recommended screenings completed at this visit	**N**	**Ab**
Developmental *(9 mo, 18 mo, 24-30 mo, 3-4 yrs)*		
Social/Emotional *(beginning at 6 mo.)*		
Autism Spectrum Disorder Screening *(18 and 24 months)*		
Maternal Depression *(0-1-mo., 2-mo., and either the 4 or 6-mo. visit)*		

Describe any "abnormal" results and referrals made:

Immunizations

☐ **Clinic, MIIC or state Immunization Record**
☐ MDH Early Childhood Immunization Form – Exemption Medical *(if relevant)*
Record immunizations received today:

If behind on schedule for age describe catch-up schedule:

Hearing Screening

Screened using pure tone audiometer or OAE? ☐ No ☐ Yes

☐ Pass ☐ Rescreen ☐ Refer
Concerns/follow-up?

Vision Screening

Visual Acuity screened using an LEA/HOTV chart or screening machine? ☐ No ☐ Yes

☐ Pass ☐ Rescreen ☐ Refer
Concerns/Follow-up?

Oral Health Assessment

Signs of decay or TX needs? ☐ No; ☐ Yes
Fluoride varnish applied? ☐ No; ☐ Yes
Referral to dental provider? ☐ No; ☐ Yes
Concerns or follow-up needed?

Referrals/follow-up from today's exam

Allergies (food, medication, environmental, insects, others)

Describe allergy specific triggers, restrictions, medications or accommodations needed for participation in Head Start

As legal guardian of this child I authorize the health care provider to release the above requested information to MVAC Head Start for the purpose of providing care to my child and supporting my family in obtaining any indicated follow-up care and/or needed treatment.

_____ _____
Parent/Guardian Signature ***Date***

_____ _____
Health Care Provider Signature *Date*

_____
Printed Name

_____
Clinic Address