JOHNSTON – LEE – HARNETT HEAD START / Early Head Start CHILD HEALTH RECORD

CHILD'S NAME:_____________________________CENTER______________SEX___DOB_________

Dear Provider: Our Federal Program **MUST** follow the North Carolina EPSDT standards. If blood lead was done at 12 & 24 months and Hgb/HCT was done before this exam, we can use those results. The required test results must be filled in below.

II. PHYSICAL ASSESSMENT *(TO BE COMPLETED BY HEALTH CARE PROVIDER).*

Date of Assessment: _____/_____/_______ Head Circumference ______ **Height**_____ins **Weight** _____lbs BMI is_____
Month Date Year

☐ 1. Normal (5% tile is < 85% tile) ☐ 2. Underweight (< 5% tile) ☐ 3. At-risk of Overweight (85% tile < 95% tile) ☐ 4. Overweight (> 95% tile)

Blood Pressure ____/____, Temperature______, Pulse _____, Respiration_____, HGB_____ /HCT_____ ☐ Normal ☐ Needs f/up

Date of Lead Testing__________ Results_______ ☐ Normal ☐ Needs follow-up

Tuberculosis: At risk? Yes___ No ____
If yes, Test Date__________ Results______

Is Child Receiving WIC? ☐ YES ☐ NO

Developmental Screening ☐ 1. Within Normal Range ☐ 2. Needs Follow-up Area(s)_______________

VISION
Name of Vision Screening Used_____________________

	RIGHT	LEFT	BOTH
FAR	20/	20/	20/
PASSED	YES	NO	
REFERRED	YES	NO	
GLASSES	YES	NO	

HEARING
Name of Instrument Used_____________________________

	1000	2000	4000
RIGHT			
LEFT			
Pure Tone ____db level			

Referred to Audiologist ENT ☐ YES ☐ NO

If any illnesses or developmental problems are checked, please provide additional information below.

○ Asthma	○ Convulsion / Seizure	○ Ear Infections	○ Skin Problems
○ Bleeding	○ Cystic Fibrosis	○ Heart Problems	○ Speech Problems
○ Bone/Muscle Problems	○ Cerebral Palsy	○ Hearing Problems	○ Stomach Aches
○ Bowel Problems	○ Dental Problems	○ Meningitis	○ Urinary / Bladder
○ Cancer / Leukemia	○ Diabetes	○ Sickle Cell Anemia	○ Other
○ Attention / Learning	○ Emotion / Behavior	○ Vision Problems	○ None

Should activities be limited? Yes____ No___ If yes, explain:_____________________________
This child is under a Doctor's care for: _____________________________

List Previous Hospitalization or Operations: _____________________________
Current Diet: Formula:_____________ Amount/Freq:__________ Breast Fed: ________ Baby/Table Food:_______________

Allergies: Environmental________________, FOOD: _____________________, MEDICATIONS: ____________________
Current Medications: _______________________________________, Referrals:_______________________

III. Findings, Treatment, and Recommendations: Please provide us with abnormal findings / diagnosis, treatment plan and or recommended follow-up or results. And additional information can be provided on the reverse side.

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IV. GENERAL STATEMENT OF CHILD'S PHYSICAL STATUS:

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An up-date Immunization record on each child (enrolled in a Head Start or Child Care Facility) is required to be on file per NC State Immunization Law –G.5 > 130A-155(b). Exemptions from NC State Immunization Law must meet requirements of the law and a statement must be on file in the child's record. ___Medical ___Religious Exemption

NCDHHS/DCD-10A NCAC 09.0803-Medications that are required to be administered at all Head Start and Early Head Start Centers must meet the requirement of the a DCD Rule and Regulations and the Head Start Parent/Employee Handbooks,-MD and Parent/Guardian must complete required forms completely-Medication Forms must be updated every 6 months.

Medical Statement: On the basis of my finding as indicated and my knowledge of this child: she/he is free from contagious and communicable disease, is receiving health care under the appropriate schedule set by the AAP-American Academy of Pediatrics is able to participate in this child care program. She/he has received or will receive an up-to-date age-appropriate immunization in accordance with the NC State Immunization Law.

(Form must show FACILITY'S STAMP & PHYSICIAN'S NAME.)

Signature of Health Care Provider____ Date__________________

Revised 08/2022