MARC: HEALTH RECORD (7 thru 12 MONTHS)

Head Start
MID-AMERICA REGIONAL COUNCIL

NAME:_____**DOB**___/___/___ **SEX:**_____**AGE:**_____
RACE/ETHINICITY:_____ **DATE of EXAM**_____

FAMILY PROFILE and HEALTH ___ No change in household since last visit
Child lives with: ___ Mother ___ Father ___ Stepparent ___ Grandparent ___Other Total adults living in home____
Total children living in home: ___ Primary caretaker for this child: _____Relationship:_____
Family's concerns/problems

NUTRITION *Problems: developmental, special diet, inappropriate weight gain/loss, chronic GI problems: __Y __ N
Breast-fed: Number of feedings in last 24 hours: ____ Length of feedings: _____ WIC __Y __N
Formula-fed: Type_____ Iron fortified: __Y __N Ounces consumed in 24 hours:____ Fluoride __Y __N
Solid foods introduced/ Age:
*If answered yes, further assessment needed

DEVELOPMENT Parent's concerns

9MONTHS
__Feeds self
__Passes object hand to hand
__Looks around to find new sounds
__Makes long strings of sounds

12 MONTHS
__Plays appropriately with toys (hugs doll)
__Bangs two objects together
__Uses one or two verbal labels for objects or people
__Stands alone 2 seconds

Standardized Screen: __P __R __not done
Further assessment needed: __Yes __No
Vision Screen: ___Normal __Abnormal
Hearing Screen: __Normal __Abnormal
Type of Screen:_____
Parent checklist given: ___Y ___N

CHILD'S HEALTH: Does the systems review note any problems or parent concerns? ___Y ___N

Major illness, injury, hospitalization, surgery (When, describe):

Allergies:
Medications taken regularly; Type/ Reason:

Mental Health:

PHYSICAL EXAMINATION

HGB/HCT_____ **LEAD**_____

Height _____**(%)** _____ **Weight**_____**(%)**_____
HC_____ **(%)**_____
Temp _____Pulse _____ Resp _____ BP_____

N	A	NE	
☐	☐	☐	Appearance
☐	☐	☐	Head
☐	☐	☐	Skin/nodes
☐	☐	☐	Eyes
☐	☐	☐	Ears
☐	☐	☐	Nose
☐	☐	☐	Mouth/throat
☐	☐	☐	Teeth
☐	☐	☐	Neck
☐	☐	☐	Chest/breasts
☐	☐	☐	Heart/pulses
☐	☐	☐	Lungs
☐	☐	☐	Abdomen
☐	☐	☐	Genitalia/Anus
☐	☐	☐	Spine
☐	☐	☐	Extremities
Neurologic			
☐	☐	☐	Muscle tone
☐	☐	☐	DTRs

Explain Abnormalities:

HEALTH EDUCATION

INJURY PREVENTION
__Car safety restraints
__Falls (stairs, gates)
__Choking management
__Water safety/temp
__Poisoning
__Child proofing
__Passive smoking

BEHAVIOR
__Parent/infant interaction, expectations
__Speech Development
__Sleep
__Separation protest
__Day Care

HEALTH PROMOTION
__Immunization
__Teething
__Cleaning teeth
__When to call doctor
__Well child care
__Dental appointment
__Family planning

NUTRITION
__Breastfeeding support
__off bottle by 1 year
__Introduction of solids
__No bottle in bed

ASSESSMENT

PLAN

TB: __Yes __No
Dental referral made: __Yes __No WIC: __Referred __Refused ___N/A
Immunizations: __Up to date __To be given today __Deferred (Explain)

Next Appointment:

Current State of Health:I have examined the above-named child and verify that this child's medical history and current state of health ___are ____are not satisfactory for participation in a childcare program. Does this child require any specialized care? ___Yes ____No
If yes, please explain:

Name and address of clinic, group, practice or other_____

Telephone number_____ FAX Number_____

Physician Signature _____Date _____ Physician Name (Print)_____
(This form expires one year from date of exam.) Form 1070 Revised 3/13/14