MARC: HEALTH RECORD (2 thru 6 Months)

Head Start
MID-AMERICA REGIONAL COUNCIL

NAME: _____ **DOB:** _____ **SEX:**_____ **AGE:**_____
RACE/ETHNICITY: _____ **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:

2 Months
__Smiles responsively
__Inspects surroundings
__Vocalizes in play
__Lifts head

4 Months
__Looks for source of sound
__Hands together
__Vocalizes to show displeasure
__Head steady in supported position

6 Months
__Reaches for objects
__Responds to own name
__Vocal imitation, takes turns vocalizing
__Rolls over (both ways)

Standardized screen: __P __F __Not Done
Further assessments needed: __Yes __No
Vision screen: ___Normal __Abnormal
Hearing screen: ___Normal __Abnormal
Type of screen_____
"Parent checklist" given __ Yes ___No

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/Behavioral Concerns:

PHYSICAL EXAMINATION

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

HEALTH EDUCATION

INJURY PREVENTION
__Car safety restraints
__Falls, Infant walker
__Burns
__Choking management
__Sleep position
__Passive smoking

BEHAVIOR
__Parent/infant interaction
__Sleep
__Inappropriate expectations
__Daycare/babysitters

HEALTH PROMOTION
__Immunizations
__Thermometer use, Tylenol
__Teething, wipe teeth
__When to call doctor
__Well-child care
__Family planning

NUTRITION
__Breastfeeding
__No solids until 4 months
__Formula preparation
__Infant held (no bottle in bed)

ASSESSMENT

PLAN

WIC: __Referred ___Refused ___N/A
Newborn Screening: ___Up to date ____To be done today
Immunizations: ___Up to date ___To be given today ____Deferred
(Explain

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 the date of exam.) Form 1070 Revised 3/13/14