Mid America Head Start: HEALTH RECORD (13 MONTHS thru 2 YEARS)

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: special diet, inappropriate weight gain, anemic, lead poisoning, chronic GI problems, major food allergies, refusal of any food group, developmental: __Y __N

Usual Servings Per Day: ___Dairy ___Formula ___Breast ___Vegetables
___Breads, cereal, rice and pasta ___Meat, poultry, fish, eggs and dry beans ___Fruits

WIC __Y __N

Fluoride: __Y __N

*If answered yes, further assessment needed

DEVELOPMENT Parent's concerns

15 MONTHS
__Waves bye-bye
__Is interested in all around him/her
__Puts block in cup
__Uses vocalization to request objects and direct attention
__Stoops and recovers

18 MONTHS
__Drinks form a cup
__ Brings you item when asked
__Says six words
__Asks for familiar toys that are not around
__Responds to "give me"
__Walks backwards

2 YEARS
__Uses spoon
__ Builds tower of cups
__ Combines two words
__Follows two-part directions
__Kicks ball forward

Standard screen __P __F __Not Done
Further assessment needed: __Yes __No
Vision Screen: __Normal __Abnormal
Hearing Screen: __Normal __Abnormal
Screen used: __ABR __OAE
___TDH Hearing Checklist

CHILD HEALTH: Does the systems review note any problems or parent concerns: __Yes ___No Explain:
Major illnesses, injury hospitalization, surgery (since last visit):

Allergies:
Medication taken regularly (Type/Reason):
Dental Care:
Mental Health:

PHYSICAL EXAMINATION

HCT/HGB_______ 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
__Choking, unsafe toys
__Poisoning
__Burns
__Water safety/temp
__Outdoor safety
__Supervised play
__Electrical injury
__Passive smoking

BEHAVIOR
__Parent/infant interaction
__Social interaction
__Limit TV
__Set limits
__Sibling rivalry
__Toilet training

HEALTH PROMOTION
__Immunizations
__Smoking in home
__Well child care
__Dental care, appt
__Family planning
__Day care

NUTRITION
__Healthy diet/snacks
__Iron rich foods
__Physical activity
__Weaning
__Off bottle by age 1

ASSESSMENT

PLAN

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