

**GCCARD HEAD START**  
**EPSDT / SCREENINGS / PHYSICAL EXAMINATION / ASSESSMENT**  
**INFANT FORM**  
**(AGE 1 MONTH THROUGH 30 MONTHS)**

**(Parents Complete This Section)**

<b>CHILD'S NAME:</b>	<b>SEX:</b>	<b>BIRTHDATE:</b>
<b>PARENT/GUARDIAN NAME:</b>	<b>PHONE:</b>	<b>PRINT DOCTOR'S NAME:</b>
<b>PARENT/GUARDIAN ADDRESS:</b>		
I give permission for the Head Start Program to request and maintain a copy of my child's protected health information.		
<b>Signature</b>		<b>Date:</b>
<b>HEAD START CENTER NAME AND ADDRESS: GCCARD Head Start, 711 N Saginaw Street, Suite 206, Flint, MI 48503</b> <b>Phone: (810) 235-5613 Fax: (810) 341-5852</b>		

**(Physician Office Complete This Section)**

<b>A. Exam Date</b>	Yrs.      Mos.	Well Child <input type="checkbox"/> 1mo <input type="checkbox"/> 2mo <input type="checkbox"/> 4mo <input type="checkbox"/> 6mo Visit Age: <input type="checkbox"/> 9mo <input type="checkbox"/> 12mo <input type="checkbox"/> 15mo <input type="checkbox"/> 18mo <input type="checkbox"/> 24mo <input type="checkbox"/> 30mo
<b>B. Immunization Review</b>	<input type="checkbox"/> Up to date <input type="checkbox"/> Immunizations Needed	<b>Immunizations given today:</b>

SCREENING TESTS	Normal for Age	Atypical	COMMENTS <i>(Use additional sheets if necessary.)</i>
<b>C. Head Circumference _____</b> <b>Length _____ Weight _____</b>			
<b>D. Hearing __ Objective __ Subjective</b>			
<b>E. Vision __ Spot-Screener __ Other</b>			
<b>F. Developmental Assessment</b>			
<b>G. Dental Inspection</b>			
<b>H. Blood Lead</b> <i>(Perform at 12 months and 24 months)</i>			
<b>I. Hematocrit or Hemoglobin</b> <i>(Perform at 12 Months)</i>			
<b>J. Cholesterol</b> <i>(Test High Risk child at 24 mo.)</i>			
<b>K. Sickle Cell<sup>1</sup></b> <i>(Perform once between 6mo. and 20Yr)</i>			
<b>L. Tuberculin (TB) Test<sup>2</sup></b> <i>(Complete at 12mo. if high risk)</i>			
<b>M. Nutritional Assessment</b>			
<b>N. History</b>	<i>Comments:</i>		
<b>O. Interpretive Conference</b>	<i>Comments:</i>		
<b>P. Anticipatory Guidance</b>	<i>Comments:</i>		
<b>Q. Injury Prevention</b>	<i>Comments:</i>		

1. The test should have been performed on children born in a Michigan hospital on or after 10/1/87. For other children with all or some black heritage, the test is required prior to the child's 21st birthday unless electrophoresis for sickle cell was done when the child was at least 6 months of age and the results are known to the parent.

2. Testing should be done upon recognition of high risk factors. If results are negative, but high-risk situation continues, testing should be repeated on an annual basis.

**PHYSICAL EXAMINATION / ASSESSMENT:** All items are required by Head Start and recommended by the American Academy of Pediatrics for children age one month through 30 months. Please check appropriate columns (Normal for Age or Atypical) and provide comments on: services needed, atypical results/scores; behavior/mental health problems and reasons for items not evaluated.

	Normal for Age	Atypical	COMMENTS (Use additional sheets if necessary.)
<b>A. General Appearance</b>			
<b>B. Posture, Gait</b>			
<b>C. Speech</b>			
<b>D. Head</b>			
<b>E. Skin</b>			
<b>F. Eyes:</b>			
<b>G. Ears:</b>			
<b>H. Nose, Mouth, Pharynx</b>			
<b>I. Teeth</b>			
<b>J. Heart</b>			
<b>K. Lungs (include asthma)</b>			
<b>L. Abdomen (include hernia)</b>			
<b>M. Genitalia</b>			
<b>N. Bones, Joints, Muscles</b>			
<b>O. Neurological / Social</b>			
(1) Gross Motor			
(2) Fine Motor			
(3) Communication Skills			
(4) Cognitive			
(5) Self-Help Skills			
(6) Social Skills			
<b>P. Glands (Lymphatic/Thyroid)</b>			
<b>Q. Muscular Coordination</b>			

**R. Allergies – Food/Medication/Environment (Please list):**

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**S. Other:**

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Should the child's activity be restricted due to physical defect or illness?  Yes  No  
 If yes, check below and explain degree of restriction:  Classroom  Playground  Gym  Swimming  Sports  Camp  Other

FINDINGS, TREATMENTS AND RECOMMENDATIONS			
ABNORMAL FINDINGS / DIAGNOSIS	TREATMENT PLAN	RECOMMENDED FOLLOW-UP OR RESULTS	DATE

**PHYSICIAN NAME AND ADDRESS (PLEASE PRINT):**

**PHONE:**

**FAX:**

**PHYSICIAN'S SIGNATURE**

**Date**

REVIEWED BY \_\_\_\_\_  
 INITIALS (STAFF ONLY)