

GCCARD HEAD START
EPSDT / SCREENINGS / PHYSICAL EXAMINATION / ASSESSMENT
EARLY CHILDHOOD FORM
(3 YEARS THROUGH 4 YEARS)

(Parents Complete This Section)

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

(Physician Office Complete This Section)

A. Exam Date	Yrs. _____ Mos. _____	Well Child Visit Age: <input type="checkbox"/> 3Yr <input type="checkbox"/> 4Yr
B. Immunization Review	<input type="checkbox"/> Up to date <input type="checkbox"/> Immunizations Needed	Immunizations given today:

SCREENING TESTS	Normal for Age	Atypical	COMMENTS <i>(Use additional sheets if necessary.)</i>
C. Blood Pressure _____ <i>(Perform at 3Yr and 4Yr)</i>			
D. Height _____ Weight _____			
E. Vision: <input type="checkbox"/> SPOT or SNELLEN Chart <input type="checkbox"/> Other _____			
F. Hearing: <input type="checkbox"/> Objective (Audiometer) <input type="checkbox"/> Other _____			
G. Dental Inspection Fluoride application date: _____			
H. Blood Lead <i>(If never tested, perform between 3Yr and 5Yr)</i>			
I. Hematocrit or Hemoglobin <i>(Perform if not previously tested or cannot be verified)</i>			
J. Cholesterol <i>(Test High Risk child at 3 Yr and 4Yr)</i>			
K. Sickie Cell¹ <i>(Perform once between 6mo. and 20Yr)</i>			
L. Tuberculin (TB) Test² <i>(Complete at 12mo. if high risk)</i>			
M. Nutritional Assessment			
N. Interpretive Conference	<i>Comments:</i>		
O. Anticipatory Guidance	<i>Comments:</i>		
P. Injury Prevention	<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 3 years through 4 years. 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.)
A. General Appearance			
B. Posture, Gait			
C. Speech			
D. Head			
E. Skin			
F. Eyes:			
G. Ears:			
H. Nose, Mouth, Pharynx			
I. Teeth			
J. Heart			
K. Lungs (include asthma)			
L. Abdomen (include hernia)			
M. Genitalia			
N. Bones, Joints, Muscles			
O. Neurological / Social			
(1) Gross Motor			
(2) Fine Motor			
(3) Communication Skills			
(4) Cognitive			
(5) Self-Help Skills			
(6) Social Skills			
P. Glands (Lymphatic/Thyroid)			
Q. Muscular Coordination			

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

S. Other:

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: _____

Updated 5/1/25 /bmh **PHYSICIAN'S SIGNATURE** _____ **Date** _____
 REVIEWED BY _____ INITIALS (STAFF ONLY)