Community Action Organization of WNY Head Start/Early Head Start

Well-Child Health Assessment

Information on this form is considered CONFIDENTIAL and must not be disclosed without proper authority.

Please complete all sections per the American Academy of Pediatrics (AAP) guidelines

*Child's Name: ____________________________ *Date of Birth:_____________ Gender: ☐M ☐F *Date of Exam: _____________

*****If child has ANY allergies, please attach a completed OCFS-6029 Anaphylaxis Plan, as required per NYS Law.**

*Does child have any **Food Intolerances** (not true allergies): ☐ No ☐ YES (Specify)____

*Does child have **ANY Allergies**: ☐ No ☐ YES (Specify)____

*Does child **currently take Medications**: ☐ NO ☐ YES (Specify)____

*Does child have any **Acute or Chronic Illnesses**: ☐ NO ☐ YES (Specify)____

*Behavioral Concerns: ☐ NO ☐ YES ____

***Lead**	**Lead Risk Assessment** ☐ No Risk Factors ☐ Risk Factors Present	**Lead Testing** 12 mos: Date___________ Level ________mcg/dl 24 mos: Date___________ Level ________mcg/dl Treatment needed: ☐ NO ☐ YES (Specify)	
***Blood Count**	12 mos: Date___________ HGB ___________g/l 24 mos: Date___________ HGB ___________g/l		Treatment needed: ☐ NO ☐ YES (Specify)
***Sickle Cell Risk Screening**	☐ Performed at Birth Date: ____/____/____	Result: ☐ Normal ☐ +Disease ☐ +Trait	Treatment needed: ☐ NO ☐ YES (Specify)

***Vision**	**Right**	**Left**	**Both**
Gross (<3 years)	☐ Normal ☐Abnormal	☐Normal ☐Abnormal	☐Normal ☐Abnormal
Acuity (>3 years)	20/__________	20/__________	20/__________
☐ Referred	☐ Strabismus	☐ Strabismus	☐ Child Wears Glasses

***Hearing**	**Right**	**Left**
	☐ Myringotomy Tube	☐ Myringotomy Tube
Gross (<3 years)	☐ Normal ☐ Abnormal	☐ Normal ☐ Abnormal
Acuity (>3 years)	☐ 500 dB ☐ 1000 dB ☐ 2000 dB ☐ 4000 dB	☐ 500 dB ☐ 1000 dB ☐ 2000 dB ☐ 4000 dB

*Height: ____________

*Weight: ____________lbs

*Blood Pressure: __________mm/Hg

*Head Circ. (Infant): _________

BMI: ____________

***Tuberculosis (TB) Risk Assessment**

☐ No Risk Factors

☐ Risk Factors Present:

Considered to be at high risk for TB if the answer is yes to one or more of the following:

☐Contacts with individuals who have infectious TB
☐ Children who are born outside of the United States
☐ Children determined to have abnormal chest x-rays related to signs of TB
☐ HIV infected children
☐ Children with low immune systems
☐ Children with medical risk factors: Hodgkin's disease, Lymphoma, Diabetes Mellitus
☐ Chronic Renal Failure, Malnutrition
☐ Children frequently exposed to adults that are HIV infected, homeless, residents of nursing homes,
☐ Migrant farm workers

***ASSESSMENT**	Normal	Abnormal	Referred
General Appearance			
Posture, Gait			
Speech			
Head			
Skin			
Eyes External Aspect			
Optic Fundoscopic			
Cover Test			
Ears External Canal			
Nose, Mouth, Pharynx			
Dental - Teeth / Gums			
Heart			
Lungs			
Abdomen (include hernia)			
Genitalia			
Bones, Joints, Muscles			
Neurological / Social			
Gross Motor			
Fine Motor			
Communication Skills			
Cognitive			
Self-Help Skills			
Social Skills			
Glands (Lymph/Thyroid)			
Muscular Coordination			
Other			

*ATTACH CHILD'S IMMUNIZATION RECORD

If child is not up to date, please indicate specific follow-up dates. OCFS licensing regulation 418.1-11(e)(1) requires Head Start to see evidence of specific follow up appointment dates before it may allow a child to enter program. This facility requires that children who are enrolled in a group care setting have received age-appropriate preventive health services, including screenings and immunizations that meet the current recommendations of the American Academy of Pediatrics. This schedule is available at https://downloads.aap.org/AAP/PDF/periodicity_schedule.pdf.

Based on information gathered during this examination, I find that this child currently appears to be free from contagious or communicable diseases, is receiving health care in accordance with the AAP schedule, and is able to safely attend child day care.

*Signature of Examiner____

*Print Name (or stamp) ____

Address____

*Phone#____

Completed by (if different than Examiner) ____________________________

Date Form Completed ____/____/____

** = Required by Federal Head Start Program Performance Standards and/or NYS OCFS*