



CHILD'S NAME	DATE OF BIRTH	CLASSROOM
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Early and Periodic Screening Diagnostic and Treatment (EPSDT) exam required.

These items are required by Federal Head Start regulations and the MN C&TC Schedule of Age-Related Screening Standards.

Exam Date: _____

Periodicity Visit for (Check): ☐ 0-1 mo ☐ 2 mo ☐ 4 mo ☐ 6 mo ☐ 9 mo ☐ 12 mo ☐ 15 mo ☐ 18 mo ☐ 24 mo ☐ 30 mo

VISION			ORAL EXAM		
Vision – External Exam Risk Assessment Corneal Light Reflex Cover Test	☐ Normal ☐ Abnormal ☐ Pass ☐ Refer ☐ Pass ☐ Refer ☐ Pass ☐ Refer	Were teeth examined? ☐ Yes ☐ No Fluoride Applied ☐ Yes ☐ No Referred to Dentist ☐ Yes ☐ No Comments:			
IMMUNIZATIONS Please attach Immunization Record					
Comments: ☐ Wearing corrective lenses					
HEARING					
OAE: ☐ Pass ☐ Refer					
Hearing – External Exam Risk Assessment Observations-Complaints/Behaviors Result of Newborn Screening	☐ Normal ☐ Abnormal ☐ Pass ☐ Refer ☐ Pass ☐ Refer ☐ Pass ☐ Refer	Given today: ☐ DTaP/DT ☐ Polio ☐ MMR ☐ HIB ☐ Hep A ☐ Hep B ☐ Varicella ☐ Other: _____ ☐ None Immunization Status: ☐ Up-to-Date ☐ Catch-Up Schedule ☐ Parent Declined			
OTHER CONDITIONS					
Asthma ☐ Yes ☐ No Current issue: ☐ Yes ☐ No or RAD ☐ Yes ☐ No Does this child have rescue medication? (inhaler/neb or other) ☐ Yes ☐ No					
HEIGHT _____ in _____ lbs _____ oz	HEAD CIRCUMFERENCE _____ cm	Allergies ☐ Yes ☐ No Describe: Does this child have rescue medication? (Epi-Pen or other) ☐ Yes ☐ No			
HEMOGLOBIN _____ g/dL	LEAD _____ µg/dL	Food Restrictions ☐ Yes ☐ No *Not food Preferences* ☐ Lactose Intolerant Other Conditions that require special care while at Head Start? (medications or accommodations) ☐ Yes ☐ No Describe:			
Date of Service*: _____ *Prior Date Acceptable ☐ Today/Pending ☐ Completed					
Date of Service*: _____ *Prior Date Acceptable ☐ Today/Pending ☐ Completed					
PHYSICAL EXAM					
EXAM	NORMAL	ABNORMAL	EXAM	NORMAL	ABNORMAL
Skin	☐	☐	Chest	☐	☐
Nodes	☐	☐	Cardiovascular	☐	☐
Head	☐	☐	Abdomen	☐	☐
Eyes	☐	☐	Genitourinary	☐	☐
Ears	☐	☐	Neurological	☐	☐
Nose	☐	☐	Musculoskeletal	☐	☐
Mouth	☐	☐	Extremities	☐	☐
Neck	☐	☐	Motor Ability	☐	☐
Social Emotional/Developmental Concerns ☐ Yes ☐ No ☐ Speech concern Please Describe:					
***Is the child up to date on a schedule of age-appropriate health care? ☐ Yes ☐ No If no, what is not complete:					
Comments:					

Referrals/Follow-Up	☐ Yes ☐ No If yes, to whom?	Appointment Date:
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Health Provider's Contact Information and Signature

Provider Name (Print): Provider Signature: Date Form Completed: Phone Number:	Clinic Name/Address (Stamp acceptable)
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Parent – Sign below: I hereby give my permission to the Provider/Clinic listed above to release information regarding the medical care provided to my child to CAP Agency Head Start. I reserve the right to revoke my permission at any time and this release will automatically expire one year after the date of my signature.

Parent/Guardian Signature

Date