Community Development Institute Head Start
Serving Beaver County, PA
HEALTH CARE PROVIDER'S STATEMENT OF HEALTH

Note to provider: Please provide the information below based on the most recent well child exam. Place a check mark in the box ☒ and/or **write-in** your answer.

Disclaimer- this form does not request all of the data from a complete EPSDT exam and does not substitute for a full unclothed examination by a health care provider.

For items marked with (*,+, √), please refer to **FOR OFFICE USE ONLY** section at the end of the form.

Child's Name:	**DOB:** ____/____/____	**Date:** ____/____/____

Is this child up to date on all well child care? ..... ☐ **Yes** ☐ **No**

If no, please explain what is needed: _____

MOST RECENT MEASUREMENTS

(+) Height:____ inches.	(+) Weight: ____ lbs	(+) Head Circumference:____ in (EHS only)	(+) BMI: ____ (HS only) (√) BP: ____ (HS only)

HEARING SCREENING (*)

Date: ____/____/____ ..... ☐ Pass or ☐ Fail

If failed, please describe follow up recommendations:_____

VISION SCREENING (*)

Date: ____/____/____ ..... ☐ Pass or ☐ Fail

If failed, please describe follow up recommendations:_____

LEAD TEST (√)

Date: ____/____/____ Results: ____ ug/dl Normal or Abnormal (Circle one)

If abnormal, please describe treatment plan:_____

HCT/HGB TEST (√)

Date: ____/____/____ Results: ____ Normal or Abnormal (Circle one)

If abnormal, please describe treatment plan:_____

CDC GROWTH CHART MEASUREMENTS (√)

Note: Healthcare provider please attach a copy of the completed growth chart with this document.

SPECIAL CONDITIONS OR CONSIDERATIONS

Please list any medical conditions (including severe, life threatening anaphylactic reactions, nutritional concerns, abnormal findings, and disabilities that must be supported by the program. _____

_____

Complete the Individualized Health Care Plan (Form#1274/1275) or Plan for Injectable Medications (Form#603/1229)

IMMUNIZATION	DATE	DATE	DATE	DATE	DATE	COMMENTS
DTap/DTP/Td						
POLIO						
HIB						
HEP B						
MMR						
VARICELLA						
PNEUMOCOCCAL						
INFLUENZA						
OTHER						

Health Care Providers Name:		
Address:	**Phone:**	**Fax:**
Signature:		**Date:** ____/____/____