

PHONE: 910-487-9800

HEAD START
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Fayetteville, NC 28314

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Health Check – EPSDT (Early, Periodic, Screening, Diagnosis, & Treatment)

ALL of the following items must be included in the Health Check to meet our Funded Requirements for Enrollment
(Based on the Age of the child)

Schedule of periodicity: 2, 4, 6, 9, 12, 15, 18 months and 2, 3, 4 years old

Date of Assessment: _____

Child's Name: _____ Sex: M F DOB: _____

Head Start Center _____ Teacher: _____

Height:	Pulse:	Lead Level:
Weight:	Length (Infant):	Hgb/Hct:
BP:	Head Circum (Infant):	TB Test Results:

Exam	Normal? (Circle One)	Abnormal Findings/Comments/Follow up/Referrals Required
Vision	Yes No	Glasses? Yes No
Hearing	Yes No	Hearing Device? Yes No
Developmental/Behavioral Assessment	Yes No	
General Appearance	Yes No	
Posture/Gait	Yes No	
Speech	Yes No	
Head	Yes No	
Eyes/Sclera/Pupils	Yes No	
Ears	Yes No	
Nose/Mouth/Throat	Yes No	
Teeth/Gums	Yes No	
Heart	Yes No	Murmur? Yes No
Lungs	Yes No	
Abdomen	Yes No	Hernia? Yes No Repaired
Skin	Yes No	
Asthma - Please provide Asthma Action Plan	Yes No N/A	Asthma Follow up evaluation needed: 3 months _____ 6 months _____
Allergies	Yes No N/A	
Restrictions/Special Needs	Yes No N/A	

Anticipatory Guidance:

- Asthma Education
 Injury prevention
 Sleep positioning
 Other: _____
 Lead poisoning
 Violence prevention
 Nutritional Counseling

Health Care Provider Signature

Date

Printed Health Care Provider Name

Phone Number