West River Head Start

WELL CHILD FORM

Last Name	First Name	Sex	Child's Date of Birth
Parent / Guardian:			Date of Exam
Address:	City, State, Zip		
Previous Health:			
Current Medications:			

Physical Assessment:

Are the following normal?	**Normal (yes/no)**	**Describe problems/abnormal findings:**
General		
ENT		
Respiratory		
GI		
Ortho		
Neuro		
Eyes/Vision		
Dental		
Cardiac		
GU		
Skin		
Endocrine		
Lead Level	Declined by physician **(Initial here)** _____	If not evaluated at this visit, has the child had a lead level drawn in the past? Date: _____ Level: _____
Hemoglobin	Declined by physician **(Initial here)** _____	If not evaluated at this visit, has the child had a hemoglobin level drawn in the past? Date: _____ Level: _____

Immunizations: Current / Up-to-date (check one) ☐ Yes ☐ No

Attach updated immunization record if any vaccines were given to bring child up-to-date.

Lab Values / Vital Signs: Record the actual values obtained for this section.	Height:	Weight:	BP:
	P:	R:	T:

Comments/Recommendations:

Any referrals made? ☐ No ☐ Yes If yes, to whom?

Please fill out this form completely so we may comply with government regulations. Thank you.

Provider Name (printed):_____ Date:_____

Provider Signature:_____ Date:_____

Affiliated Clinic:_____ Tel:_____ Fax:_____

Please return form to:			
West River Head Start	West River Head Start 1004 7th Street SW Mandan, ND 58554 Tel (701) 663-9507 Fax (701) 663-9643	West River Head Start PO Box 197 Carson, ND 58529 Tel (701) 622-3505 Fax (701) 622-3236	West River Head Start PO Box 197 New Salem, ND 58563 Tel (701) 843-8061 Fax (701) 843-8061

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