NMCAA PROGRAM PHYSICAL SCREENING

nmcaa Head Start/Early Head Start

The purpose of this screening is to assess the physical and developmental health of children enrolling in a NMCAA Child and Family Development Program. This physical will determine if a child is able to participate in preschool programming or home visiting programs and for staff to support each child's growth and school readiness.

Health Care Provider: Please complete all boxed screening components below with specific results.
Check the appropriate "[ ] is or [ ] is not" and sign.

Well Child Visits	❑2 Week	❑1 Month	❑2 Month	❑4 Month	❑ 6 Month	❑9 Month	❑12 Month
	❑15 Month	❑18 Month	❑ 24 Month	❑ 30 Month	❑3 Years	❑4 Years	❑5 Years

Child's Name _____ Date of Birth _____ ❑ Male ❑ Female

PLEASE COMPLETE ALL OF THE REQUIRED EPSDT SCREENING COMPONENTS BELOW

Height_____ **Weight**_____ **BMI**_____ **Head Circumference**_____ **Blood Pressure**_____
(beginning at 24 months) (1-24 Months)

Results: Normal Abnormal Comments: _____

Physical Inspection ❑ Normal ❑ Concerns:_____

Oral Inspection ❑ Normal ❑ Concerns: _____ ❑ Refer to DDS

Nutritional Assessment ❑ Normal ❑ Suspect ❑ Atypical ❑ Not Performed

Hearing Exam was: ❑ Subjective ❑ Objective ❑ Pass ❑ Fail ❑ Comments:_____

Vision Exam was: ❑ Subjective ❑ Objective ❑ Pass ❑ Fail ❑ Comments:_____

Autism Spectrum Disorder (18 and 24 months) ❑ Normal ❑ Concerns/referral:_____

BLOOD TESTS

Lead: Required at 12 and 24 months. If child has not been tested at 24 months, must screen.
Hemoglobin: Required at 12 months. If child has not been tested at 12 months, must screen.

Lead Date Tested: _____/_____/_____ Results_____

Hemoglobin Date Tested: _____/_____/_____ Results_____

Cholesterol Risk Assessment ❑ Normal ❑ Abnormal ❑ Not at Risk

Immunization Status: ❑ Up to Date ❑ Shots given: _____ ❑ Shots needed:_____

Pease indicate if the child has been, or is being treated for any of the following:

Asthma	❑ Yes	❑ No	Neurological Concerns	❑ Yes	❑ No
Allergies	❑ Yes	❑ No	Orthopedic Concerns	❑ Yes	❑ No
Anemia	❑ Yes	❑ No	Developmental Concerns	❑ Yes	❑ No
Diabetes	❑ Yes	❑ No	Other: _____	❑ Yes	❑ No
Seizures	❑ Yes	❑ No			

Referrarals/Recommendations:_____
_____
_____

HEALTH STATEMENT - I have, on this date, screened this child in order to determine physical fitness and/or apparent evidence of communicable disease. In my opinion this child **[ ] is [ ] is not** physically and emotionally able to participate in educational activities. If the child is not able to participate, please explain above.

_____ _____
Health Provider Signature & Date **Name of Providers Office**

_____ _____
Date of Exam **Date of next exam**

Parent takes this form to physician and returns it in envelope provided.

Return to: _____ **Fax:** _____ **Phone:** _____

FOR NMCAA OFFICE USE ONLY: Date Received _____ **Time and Mileage to Appointment** _____