Olympic Educational Service District 114

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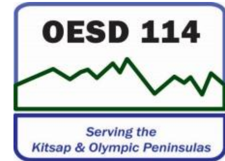

WELL CHILD EXAM

Olympic ESD Head Start/ECEAP/Early Head Start

Attention: ____

Child: ____ Birthdate ____/____/____

I give permission for a mutual exchange of information between my child's health care provider ____ and OESD 114 Head Start/ECEAP/Early Head Start concerning my child's health status. Information may be exchanged via phone, fax, e-mail or land mail.

Parent/Guardian Signature ______________________________ Date ______________

PLEASE DO NOT SEND A COPY OF CHILD'S MEDICAL RECORD. COMPLETE THIS FORM ONLY.

Date of Exam:	Current Weight:	Current Height/Length:
EPSDT Exam Completed (please circle one): 2 wk 2 mo 4 mo 6 mo 9 mo 12 mo 15 mo 18 mo 24 mo 3 yr 4 yr 5 yr		Next Exam Due:
Immunizations Given:		
Fluoride Prescribed? (Circle) YES NO	Anemia Screening Results: HCT_________ HGB_________ _______ Not Recommended	Lead Screening Results: _____mcg/dl _____ Not recommended

YES	NO	Health Status
		Are you serving as this child's primary health care provider?
		Is child up to date on an age-appropriate schedule of preventative and primary health care and immunizations are appropriate for their age?
		Is this child diagnosed as needing medical treatment for any of the following conditions: ***If yes, please note any recommendations or restrictions in Provider Comments*.**
		Any allergies or chronic health conditions?
		Is child at risk for anemia, high lead level or TB?
		Vision or hearing concerns?
		Growth or developmental concerns?
		Dental concerns?
		Was child treated for the above listed condition(s)?

Provider Comments:	
Signature of Provider:	Date: