Washtenaw ISD
A REGIONAL EDUCATIONAL SERVICE AGENCY

Washtenaw ISD Early Head Start Program
Physical Examination

Patient Information		
Child's Name	**Date of Birth**	**Date of Physical Exam**

Is child up-to-date on all well child care? □ Yes □ No

If NO, please explain what is needed: _____

This practice is the child's medical home? □ Yes □ No

Is child a WIC Participant? (FAX referral to 734-544-6725) □ Yes □ No

WELL BABY CHECK: ❑0 - 1 month ❑2 month ❑4 month ❑6 month ❑9 month ❑12 month ❑15 month ❑18 month ❑24 month ❑30 month ❑36 month

***** ALL INFORMATION BELOW IS REQUIRED AND MUST LIST DATE OF TEST WITH RESULTS *****

TYPE	DATE	RESULTS	
Height			**Normal or Abnormal** Select One
Weight			**Normal or Abnormal** Select One
Head Circumference			**Normal or Abnormal** Select One
Vision Screening		Select One	**Normal or Abnormal** Select One
Hearing Screening		Select One	**Normal or Abnormal** Select One
Hematocrit/Hemoglobin			**Normal or Abnormal** Select One
Lead*		**12 month:** **24 month:**	**Normal or Abnormal** Select One
***Blood Lead Levels are required for all children enrolled in Medicaid and the Federal Early Head Start program and must be tested at **1 and 2 years of age**.			
Oral Health Screening**			**Normal or Abnormal** Select One
****The first dental exam should be at the eruption of the first tooth and no later than **12 months of age** & repeated every 6 months (per the American Academy of Pediatric Dentistry). Also assess whether the child has a dental home. If no dental home is identified, perform a risk assessment and refer to a dental home.			

Anticipated Needs (check all that apply)	
Nutrition follow-up	☐
Dental follow-up	☐
Mental Health Intervention	☐
Other:	☐

Special Conditions or Considerations

If any screenings are failed or abnormal, please describe treatment plan or follow-up recommendations:

Please list any medical conditions (asthma, allergies, seizures, nutritional concerns, abnormal findings and/or disabilities that can be supported by our program):

Health Provider Contact Information and Signature

Print Provider Name: _____

Address: _____

Phone #: _____ FAX #: _____

_____ _____

Provider Signature **Date of Signature**

Date EHS rcvd & initials _____