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|  | **YDI Early Childhood Education & Family Development Division** |  |
| **Head Start Well Child Check 3-5 Years old** |

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| **Please Fill out completely as required by NM EPSDT and recommended by American Academy of Pediatrics for children****3-5 years old.**  | Child’s Name: | DOB: |
| Parents Name | Phone |
| Present Age yrs. Mos. |
| Date | Test | Results | Date | Test | Results |
|  | Height (no shoes, to nearest1/8 in). |  |  | Weight (Light clothingto the nearest 1/4Ib). |  |
|  | Lead at 12 mos per state ofNM EPDST |  |  | Hearing (Type of test)R/L Comments |  |
|  | Lead at 24 mos per state ofNM EPDST |  |  | Blood pressure |  |
|  | Hematocrit/Hemoglobin. |  |  | Vision (Type of test)Acuity, R/L, Strabismus |  |
| **If you have any questions please feel free to call YDI Head Start at** **Phone: 212-7212****Fax: 268-0457****Thank You for your support and working with us to determine if children are healthy and ready to learn!** |  | Normalfor age | Abnormal | NotEval. | Comments |
| a. General Appearance |  |  |  |  |
| b. Posture, Gait |  |  |  |
| c. Speech |  |  |  |
| d. Head |  |  |  |
| e. Skin |  |  |  |
| f. Eyes (1) External Aspects |  |  |  |
| (2) Optic Fundiscopic |  |  |  |
| (3) Cover Test |  |  |  |
| g. Ears (1) External & Canals |  |  |  |
| (2) Tympanic Membranes |  |  |  |
| h. Nose, Mouth, Pharynx |  |  |  |
| i. Teeth |  |  |  |
| j. Heart |  |  |  |
| k. Lungs |  |  |  |
| l. Abdomen (include hernia) |  |  |  |
| m. Genitalia |  |  |  |
| n. Bones, Joints, Muscles |  |  |  |
| 1. Neurological/Social
	1. Gross Motor
 |  |  |  |
| (2) Fine Motor |  |  |  |
| (3) Communication Skills |  |  |  |
| (4) Cognitive |  |  |  |
| (5) Self-Help Skills |  |  |  |
| (6) Social Skills |  |  |  |
| p. Glands (Lymphatic/Thyroid) |  |  |  |
| q. Muscular Coordination |  |  |  |
| r. Allergies (environmental, food) |  |  |  |
| General Statement on child’s physical status: |
| Abnormal Findings/Diagnosis | Treatment Plan | Recommended follow up or results | Date |
| a. |  |  |  |
| b. |  |  |  |
| c. |  |  |  |
| Physician Printed:  | Physician Signature:  | Date :  |

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|  | **DON’T NOT WRITE BELOW LINE: YDI OFFICE USE ONLY** |
| Received on: Received By: Entered on:  |