

# EPSDT / SCREENINGS / PHYSICAL EXAMINATION / ASSESSMENT

## INFANT FORM

## AGE ONE MONTH THROUGH 12 MONTHS

CHILD'S NAME:	SEX:	BIRTHDATE:
PARENT/GUARDIAN NAME AND ADDRESS:		PHONE:
HEAD START CENTER NAME AND ADDRESS:	C-L-M Community Action Agency Head Start/ Early Head Start/Pre School Program P.O. Box 70 524 Ashmun Street Sault Ste. Marie, MI 49783	
Phone: (906) 632-3363		
Fax: (906) 632-4255		

*PART I: To be completed before Physical Examination/Assessment*

**1. RELEVANT HISTORY AND ADDITIONAL INFORMATION (from Health History, Parent/Teacher Observations. Also enter Primary Physician name and address if form will be sent to a different provider)**

**2. SCREENING TESTS: All items are required by Head Start and recommended by the American Academy of Pediatrics for age one month through 12 month well child visits. At a minimum check appropriate boxes in RESULTS/DATE column. Enter date if done previously. Provide comments on: services needed, suspect or atypical results and reasons services were not performed.**

TEST	RESULTS/DATE	COMMENTS
<b>A. Present Age</b>	Yrs.                  Mos.	Well Child <input type="checkbox"/> 1mo <input type="checkbox"/> 2mo <input type="checkbox"/> 4mo Visit Age: <input type="checkbox"/> 6mo <input type="checkbox"/> 9mo <input type="checkbox"/> 12mo
<b>B. Immunization Review</b>	<input type="checkbox"/> Up to date <input type="checkbox"/> Immunizations Needed <input type="checkbox"/> Review Not Performed	Immunizations given today:
<b>C. History</b>	<input type="checkbox"/> Performed <input type="checkbox"/> Not Performed	
<b>D. Height _____ Weight _____ (No shoes, to nearest 1/8 in.)</b>	<input type="checkbox"/> Normal <input type="checkbox"/> Suspect <input type="checkbox"/> Atypical <input type="checkbox"/> Not Performed	
<b>E. Hearing</b>	<input type="checkbox"/> Normal <input type="checkbox"/> Suspect <input type="checkbox"/> Atypical <input type="checkbox"/> Not Performed	
<b>F. Vision</b>	<input type="checkbox"/> Normal <input type="checkbox"/> Suspect <input type="checkbox"/> Atypical <input type="checkbox"/> Not Performed	
<b>G. Developmental Assessment</b>	<input type="checkbox"/> Normal <input type="checkbox"/> Suspect <input type="checkbox"/> Atypical <input type="checkbox"/> Not Performed	
<b>H. Dental Inspection</b>	<input type="checkbox"/> Normal <input type="checkbox"/> Suspect <input type="checkbox"/> Atypical <input type="checkbox"/> Not Performed	
<b>I. Blood Lead (12 Mo. only)                          Results _____</b>	<input type="checkbox"/> Normal <input type="checkbox"/> Suspect <input type="checkbox"/> Atypical <input type="checkbox"/> Not Performed	
<b>J. Hematocrit or Hemoglobin    Hct. _____ (Perform once between 1 Mo. and 12 Mo.)    Hgb. _____</b>	<input type="checkbox"/> Normal <input type="checkbox"/> Suspect <input type="checkbox"/> Atypical <input type="checkbox"/> Not Performed	
<b>K. Sickle Cell<sup>1</sup> (Perform once between 6 Mo. and 20 Yr.)</b>	<input type="checkbox"/> Normal <input type="checkbox"/> Suspect <input type="checkbox"/> Atypical <input type="checkbox"/> Not Performed	
<b>L. Nutritional Assessment</b>	<input type="checkbox"/> Normal <input type="checkbox"/> Suspect <input type="checkbox"/> Atypical <input type="checkbox"/> Not Performed	
<b>M. Tuberculin (TB) Test<sup>2</sup>    <input type="checkbox"/> High Risk (12 Mo. if High Risk)            <input type="checkbox"/> Low Risk</b>	<input type="checkbox"/> Normal <input type="checkbox"/> Suspect <input type="checkbox"/> Atypical <input type="checkbox"/> Not Performed	
<b>N. Interpretive Conference</b>	<input type="checkbox"/> Performed <input type="checkbox"/> Not Performed	
<b>O. Anticipatory Guidance</b>	<input type="checkbox"/> Performed <input type="checkbox"/> Not Performed	
<b>P. Injury Prevention</b>	<input type="checkbox"/> Performed <input type="checkbox"/> Not Performed	

1. The test should have been performed on children born in a Michigan hospital on or after 10/1/87. For other children with all or some black heritage, the test is required prior to the child's 21st birthday unless electrophoresis for sickle cell was done when the child was at least 6 months of age and the results are known to the parent.
2. Testing should be done upon recognition of high risk factors. If results are negative but high risk situation continues, testing should be repeated on an annual basis.

**PART II: To be completed by Health Care Provider During and After Physical Examination/Assessment**

**3. PHYSICAL EXAMINATION / ASSESSMENT:** All items are required by Head Start and recommended by the American Academy of Pediatrics for children age one month through 12 months. Please check appropriate columns (Normal for Age; Atypical; or Not Evaluated) and provide comments on: services needed, atypical results/scores; behavior/mental health problems and reasons for items not evaluated..

	Normal for Age	Atypical	Not Evaluated	COMMENTS: (Use additional sheets if necessary.)
<b>A. General Appearance</b>				
<b>B. Posture, Gait</b>				
<b>C. Speech</b>				
<b>D. Head</b>				
<b>E. Skin</b>				
<b>F. Eyes:</b>				
(1) External Aspects				
(2) Optic Fundiscopic				
(3) Cover Test				
<b>G Ears:</b>				
(1) External & Canals				
(2) Tympanic Membranes				
<b>H Nose, Mouth, Pharynx</b>				
<b>I. Teeth</b>				
<b>J. Heart</b>				
<b>K Lungs</b>				
<b>L. Abdomen (include hernia)</b>				
<b>M Genitalia</b>				
<b>N. Bones, Joints, Muscles</b>				
<b>O Neurological / Social</b>				
(1) Gross Motor				
(2) Fine Motor				
(3) Communication Skills				
(4) Cognitive				
(5) Self-Help Skills				
(6) Social Skills				
<b>P. Glands (Lymphatic/Thyroid)</b>				
<b>Q Muscular Coordination</b>				
<b>R. Other</b>				

**S . General Statement on Child’s Medical Status (Please note any allergies):**

Should the child’s activity be restricted due to physical defect or illness? Yes No If yes, check below and explain degree of restriction:

Classroom Playground Gym Swimming Sports Camp Other

**4. FINDINGS, TREATMENTS AND RECOMMENDATIONS**

ABNORMAL FINDINGS / DIAGNOSIS	TREATMENT PLAN	RECOMMENDED FOLLOW-UP OR RESULTS	DATE

PHYSICIAN NAME AND ADDRESS (PLEASE PRINT):

PHONE: