MID-DELTA HEAD START
WELLNESS EXAM

Child’s Name: _______________________
Date of Birth: _______________

Provider/Clinic: ______________________
Date of Visit: ________________

A. Growth & Nutrition
Height: _______  Weight: _________  Head Circumference: _______
Comments: ________________________________________________________________

B. Anemia Screening (To be performed on all children)
Hematocrit or Hemoglobin Results: ______ Normal____  Abnormal____  Referred____
Comments: __________________________________________________________________

C. Sensory
Vision: Right Eye: _______  Normal_____  Abnormal_____  Referred_____
Left Eye: ________  Normal_____  Abnormal_____  Referred_____
Comments: _______________________________________________________________

D. Physical

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<th>Normal</th>
<th>Abnormal</th>
<th>Referred</th>
<th>Comments</th>
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<tbody>
<tr>
<td>General Appearance</td>
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<td>Blood Pressure</td>
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<td>Speech</td>
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<td>Nose, Mouth, Pharynx</td>
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<td>Bones/Joints/Muscles</td>
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HS-93 (a)
E. Lead Screening  (Medicaid children should have lead testing results by EPSDT standards. If testing is not done today please list results from last testing along with testing date.)

Results: blood Lead level#: ________    High Risk_______    Low Risk______
Normal____   Abnormal____   Referred____
Comments: _______________________________________________________________________

F. Diabetes Screening

Normal____   Abnormal____   Referred____
Comments: _______________________________________________________________________

G. Asthma Screening

Normal____   Abnormal____   Referred____
Comments: _______________________________________________________________________

H. Immunizations

Are Immunizations up to date? Yes_______    No____
If no, were immunizations given today? Yes_______    No____
What Immunizations were given? ______________________________________________________

I. Guidance

Injury Prevention    Yes_______    No____    Referred____
Comment: _______________________________________________________________________

Violence Prevention    Yes_______    No____    Referred____
Comments: _______________________________________________________________________

Nutrition Counseling    Yes_______    No____    Referred____
Comments: _______________________________________________________________________

Is child taking any medications?    Yes_______    No____
If yes please indicate: ________________________________________________________________

Additional Findings (Allergies, etc)
_________________________________________________________________________________
_________________________________________________________________________________

Follow-up Required?    Yes_______    No____
If yes, please indicate: ________________________________________________________________

Signature and Title of Provider: _______________________________________________________________________

MDCS (5/11)  HS-93 (b)