

**WBC Opportunities
Early Head Start Center
Well Child Exam
13 months-2 yrs**

Name _____
DOB _____
Age of child _____

HEAD START HEALTH REQUIREMENTS-	NUTRITIONAL ASSESSMENT/EDUCATION
---------------------------------	----------------------------------

This child is required to have a complete physical examination, including height/weight, head circumference and vision/hearing screening. A HgB/HCT, TB Questionnaire and Lead Level is required at 2years. These items are required based on Texas Health Steps Medical Checkups Periodicity Schedule. Please complete this form, sign, date and send with the parent.

	Y	N	COMMENTS (If concerns, explain below)
--	---	---	---------------------------------------

HISTORY/PARENTAL CONCERNS

			WIC
			Eats all food groups
			Drinks from a cup
			Vitamin/Fe supplement
			Feeding Problems
			Bowel Problems

ALLERGIES	<input type="checkbox"/> NKDA <input type="checkbox"/> Allergies: _____
-----------	--

SCREENING

MEDICATIONS	<input type="checkbox"/> No regular meds <input type="checkbox"/> Current meds: _____	<input type="checkbox"/> No Chronic problems <input type="checkbox"/> Chronic problems
-------------	--	---

TB Questionnaire	<input type="checkbox"/> Pass	<input type="checkbox"/> Fail
Lead Questionnaire	<input type="checkbox"/> Pass	<input type="checkbox"/> Fail
Gross Hearing	<input type="checkbox"/> Pass	<input type="checkbox"/> Fail
Gross Vision	<input type="checkbox"/> Pass	<input type="checkbox"/> Fail
Dental Screening	<input type="checkbox"/> Pass	<input type="checkbox"/> Refer
PDQ or complete Denver	<input type="checkbox"/> Pass	<input type="checkbox"/> Fail <input type="checkbox"/> NA

Y	N	MENTAL HEALTH SCREENING
---	---	-------------------------

Explain Comments

		Behavior problems/concerns
		Family stresses
		Day care (if yes, where? _____)
		Other (see comments)
		Good self esteem
		Normal sleeping

PHYSICAL EXAM	(Plot Ht., wt, HC on growth curve)
---------------	------------------------------------

Ht. _____ in _____ %	Temp _____
Wt. _____ lb _____ %	Pulse _____
HC _____ cm _____ %	Resp. _____

N	A	NE	COMMENTS
---	---	----	----------

Explain significant/Abnormal PE findings

			General (nl appearance / behavior)
			Skin (no birthmarks)
			Head (symmetrical)
			Eyes (Red reflex/Corneal light reflexes CoverTest nl)
			Oral Health teeth gums nl
			Ears (external / TM's: clear, mobile)
			Teeth/Nose/pharynx/mucous memb. (clear)
			Neck (nodes, no masses, full ROM)
			Lungs (BS = and clear)
			CV (RRR, No murmur, nl S1, S2)
			Abdomen (no HSM, no masses, good BS)
			Genitalia (F): (nl anatomy, no discharge)
			(M) testes ↓ ↓ <input type="checkbox"/> L <input type="checkbox"/> R, No hernias
			Anus (nl position)
			Extremities (symmetrical mvt, full ROM)
			Spine/Hips (stable, no hip clunk)
			Neurologic Muscle tone nl bilat. Gait (no ataxia)
			HS-48 DTRs 2+bilat. (biceps, patellar, Achilles)

DEVELOPMENTAL ASSESSMENT (if no explain below)

13-15 Months		18 Months		24 months	
Y	N	Y	N	Y	N
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Waves bye-bye		Drinks from a cup		Uses spoon spilling little	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Is interested in all sounds		Brings you item when asked		Scribbles spontaneously	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Indicates wants without crying		Says at least six words		Combines 2 word-phrases	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Walks		Walks backwards		Follow 2 part directions	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Can point to familiar objects (dog, light, etc.)		Uses voice to communicate		Kicks ball forward	
		needs most of the time			

HEALTH EDUCATION (* = Must Discuss)

	Behavior	Injury Prevention	Health Promotion	Nutrition
13-24 Mo.	<input type="checkbox"/> Talk/read with child*	<input type="checkbox"/> Car seat*	<input type="checkbox"/> Immunization	<input type="checkbox"/> 3 meals a day*
	<input type="checkbox"/> Limit TV	<input type="checkbox"/> Choking*	<input type="checkbox"/> WCC visits	<input type="checkbox"/> 3 healthy snacks/day*
	<input type="checkbox"/> Set limits/be consistent*	<input type="checkbox"/> Poisoning*	<input type="checkbox"/> Dental care, appt.	<input type="checkbox"/> Iron-rich foods*
	<input type="checkbox"/> Temper tantrums	Poison Control number	<input type="checkbox"/> Family planning*	<input type="checkbox"/> Weaning off bottle by age 15 mos.*
	<input type="checkbox"/> Sibling rivalry (2 yr)	1-800-POISON-1*	<input type="checkbox"/> Smoking at home*	
	<input type="checkbox"/> Toilet training*	<input type="checkbox"/> Burns/electrical outlets	<input type="checkbox"/> When to call clinic	
	<input type="checkbox"/> Choosing substitute caregivers*	<input type="checkbox"/> Water safety*		
		<input type="checkbox"/> Supervised play		

Assessment:

Plan:

PPD IPV 1 2 3 4 Prevnar 1 2 3 4 HIB 1 2 3 4
 Hep B 1 2 3 DTaP 1 2 3 4 MMR 1 Hepatitis A 1 2 Varicella 1
 Influenza 1 2 Lead Hgb/Hct /

Other:

Next appointment:

Date:	Nurse Signature:
Date:	Provider Signature: