

**Child Care Resource & Referral, Inc., Head Start**

Health Services Coordinator  
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**HEAD START WELL-BABY/CHILD & TEEN CHECKUP EXAM**

Child's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Sex: \_\_\_\_\_

Parent Name: \_\_\_\_\_ **Date of Exam:** \_\_\_\_\_

Name of Clinic: \_\_\_\_\_ Clinic #: \_\_\_\_\_

Printed Health Provider Name: \_\_\_\_\_ Provider Signature: \_\_\_\_\_

**Please note: These items are Federally Mandated for Head Start children in accordance with the MN EPSDT schedule of age-related standards (see reverse side for details). \*Please provide previous applicable lab results\*.**

Head Circumference \_\_\_\_\_ cm. Height \_\_\_\_\_ cm. Weight \_\_\_\_\_ kg.

Visual Acuity \_\_\_\_\_ R \_\_\_\_\_ L \_\_\_\_\_ Hearing \_\_\_\_\_ R \_\_\_\_\_ L \_\_\_\_\_

Blood Pressure \_\_\_\_\_ / \_\_\_\_\_ HCT/HGB\* \_\_\_\_\_ Lead\* \_\_\_\_\_

Urinalysis(Optional) \_\_\_\_\_ TB Questionnaire \_\_\_\_\_ Results \_\_\_\_\_

Immunizations current? Yes or No Please attach a copy of child's immunization record.

Area	N/AB	Comments	Area	N/AB	Comments
1. Head			10. Spine		
2. Face			11. Cardiovascular		
3. Neck			12. Abdomen		
4. Eyes			13. Genitalia		
5. Ears			14. Extremities		
6. Nose			15. Joints		
7. Mouth			16. Muscle Tone		
8. Throat			17. Skin		
9. Chest			18. Neurological		

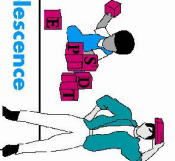
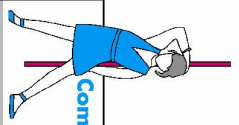
APGAR SCORES: 1 minute: \_\_\_\_\_ 5 minutes: \_\_\_\_\_

- Does child have any allergies? (food, drug, insect, other) No Yes If yes, please circle type and give recommendations: \_\_\_\_\_
- Is child developing appropriately for his/her age? No Yes If no, what modifications are needed: \_\_\_\_\_
- Is a special diet necessary? No Yes Please identify restrictions: \_\_\_\_\_
- Is there a condition which may result in an emergency? No Yes Please specify: \_\_\_\_\_
- Please indicate any notable health problems: \_\_\_\_\_
- If noted, any restrictions or recommendations: \_\_\_\_\_

**I authorize this information to be faxed from my medical facility to Head Start.**

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

# Minnesota Child and Teen Checkups (C&TC) Early and Periodic Screening, Diagnosis and Treatment (EPSDT)



Schedule of Age-Related Screening Standards

Components	Infancy				Early Childhood				Late Childhood				Adolescence							
	0-1 mo.	2 mo.	4 mo.	6 mo.	9 mo.	12 mo.	15 mo.	18 mo.	24 mo.	3 yrs	4 yrs	5 yrs	6 yrs	8 yrs	10 yrs	12 yrs	14 yrs	16 yrs	18 yrs	20 yrs
Anticipatory Guidance & Health Education	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Measurement — height & weight	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
• head circumference	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
• blood pressure										✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Health History including- mental health, nutrition, chemical use	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Development: social-emotional/mental health, cognitive, speech/language, fine/gross motor	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Physical — including sexual development, oral exam	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Immunizations/Review	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Laboratory Tests										(if never tested)										
• Blood lead																				
• Newborn Metabolic (if indicated)																				
• Urinalysis											(optional)									
• Hemoglobin/hematocrit																				
• Other: Cholesterol, STD, TB (as indicated)																				
Vision	*S	S	S	S	S	S	S	S	S	**0	0	0	0	0	0	0	0	S	0	S
Hearing	***0/S	S	S	S	S	S	S	S	S	***0/S	0	0	0	0	0	0	0	S	0	S
Dental Checkups — verbal referral										✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓

\*S = subjective, by history.      \*\*0 = objective, by appropriate standard testing method.  
(Also ask the subjective vision and hearing history questions.)      \*\*\*0/S = either at this age

↔ Indicates range to provide service one time.

↔ Additional screening services and/or specific screening components may be provided at other intervals as indicated.

**See reverse side for more information.**



Developed jointly by the Minnesota Departments of Human Services and Health

See FACT Sheets in C&TC Provider Guide