ROCKY MOUNTAIN DEVELOMENT COUNCIL, INC. (RMDC)
HEAD START
WELL CHILD EXAM

Date of Exam _____

Child'sName_____DOB _____

Parent(s)/Guardian _____

Health Care Professional's Printed Name _____

Dear Health Care Provider and Parents:
Head Start is a Federal Program and its standards align with Early and Periodic Screening, Diagnosis and Treatment Program of the State of Montana, including lead screening guidelines. Our children are required to have a physical exam (Well Child Check) and dental exam yearly. The Health Services Advisory Committee strongly agrees with the above program standards and recommends that Hemoglobin or Hematocrit be completed at the child's visit with you. Passing scores of these screens will help to insure that our children are in their most healthy state for the best possible learning.

Child's Height _____ Weight _____ BMI %_____ Blood Pressure _____

Allergies: _____

PHYSICAL EXAMINATION	NORMAL	ABNORMAL	REFER	NOTES
General appearance				
Nose/Throat/Mouth				
Teeth				
Heart				
Lungs				
Abdomen				
Bowel/Bladder				
Bones/Joints/Muscles				
Gross motor				
Fine motor				
Neurological				
Speech/Language				
Behavioral Screening				
Vision				
Hearing				
Nutrition (including food insecurity)				
Hgb/Hct				
Lead Screen (please indicate date if done at a prior well child exam)				

Signature: _____ Date: _____
(Health Care Professional)

Please attach a copy of the child's full immunization record. (Please request parent signs the consent form for child's immunes to be entered into imMTrax, the Montana Immunization Information System.)

Information can be faxed to 447-1629, Attn: Health Manager, RMDC Head Start.

For Office Use

Health Manager _____

ChildPlus Scan/Date _____ (Initial and Date)

Shred