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

Date of Exam: _____

Child's name: _____ DOB: _____

Parent(s)/Guardian: _____

Health Care Professional's Printed Name: _____

Dear Health Care Provider and Parents:
Head Start requires that all children have a yearly well child exam that meets EPSDT (Early & Periodic Screening Diagnosis & Treatment) requirements. Lead levels should be checked if not previously done at 12 & 24 months. Our Health Services Advisory Committee strongly recommends that blood iron be checked during this exam.

Child's Height: _____ Weight:_____ BMI percentile:_____ 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 Test (please indicate date if done at a prior well child exam)				

Signature: _____ Date: _____
(Health Care Professional)

Exam reports can be faxed to: (406) 447-1629
Attn: Health Manager, Head Start.