COASTAL COMMUNITY ACTION, INC

CHILDREN'S SERVICES HEALTH ASSESSMENT REPORT

PARENT COMPLETE

Please Print Clearly

Child's Name _____
(Last) (First) (Middle)

Birth Date:_____/_____ /_____ (mm/dd/yyyy)

Address: _____City:_____ State:_____ Zip:_____

Parent/Guardian Name:_____ Phone:_____

Parental Consent : I agree to allow my child's health care provider and CCA Head Start personnel to discuss information on this form.

Signature: _____ Date:_____

HEALTH CARE PROVIDER COMPLETE

Date of Health Assessment: ____/____/_____

Immunizations - Attach a copy of immunization record

Pertinent Illnesses, Risks or Developmental Problems: (Check all that apply)

- ☐ Allergy
- ☐ Anemia
- ☐ Asthma
- ☐ Attention/Learning
- ☐ Bleeding Problems
- ☐ Cancer/Leukemia
- ☐ Cerebral Palsy
- ☐ Cystic Fibrosis
- ☐ Dental Problems
- ☐ **NONE**
- ☐ Diabetes
- ☐ Emotional/Behavioral
- ☐ Encopresis
- ☐ Enuresis (Daytime)
- ☐ Genetic Disorders
- ☐ Heart Problems
- ☐ Hearing Problems
- ☐ Kidney Problems
- ☐ Orthopedic Problems
- ☐ Prematurity (<32 wks. EGA)
- ☐ Seizures/Convulsions
- ☐ Sickle Cell Anemia
- ☐ Speech/Language
- ☐ Tuberculosis ☐ at risk for TB
- ☐ Vision Problems
- ☐ Other:_____

Lead: date of test/results: _____/_____ date of test/results: _____/_____

Head Start requires a blood lead test at 12 and 24 months of age, please note all past test dates and applicable results

Screening Results

Development

Screening Tool(s) Used:

- ☐ 1 - PEDS
- ☐ 2 - ASQ
- ☐ 3 - IDI/CDI
- ☐ 4 - PSC
- ☐ 5 - ASQ-SE
- ☐ 6 - Brigance

Within Normal	Concern Identified	Referred to Specialist	Comments
☐	☐	☐	

Hearing

Screening Tool Used:

- ☐ OAE
- ☐ Audiometry
- ☐ Subjective (ages 0-3 only)

	1000 Hz	2000 Hz	4000 Hz
Right			
Left			

Indicate Pass (P) or Refer (R) in each box. Refer means failure at any frequency in either ear at >20dB

- ☐ Pass
- ☐ Re-screen scheduled due to middle ear fluid. Re-screen in ___wks.
- ☐ Referral to Audiologist/ENT
- ☐ Previously diagnosed with hearing loss, no screening needed.

Vision

Please remember that vision screening is not a substitute for a complete eye exam.

Far:	Both	Right	Left
Test Used:			

- ☐ Subjective (ages 0-2 only)
- ☐ Test performed with corrective lenses

- ☐ Pass
- ☐ Referral to Eye Doctor (check if Y)
  Refer if worse than 20/40 in either eye, a two line difference between eyes or unable to test.
- ☐ Child has a diagnosed vision condition AND has had an eye exam in last 12 months.

Physical Examination

Weight:____lbs. Height:____ft. _____in.

Body Mass Index (BMI) - for age

- ☐ 1 - Normal
- ☐ 2- Abnormal
- ☐ 3 - At-Risk (85%ile to <95%ile)
- ☐ 4 - Overweight (95%ile)

Blood Pressure: _____/_____ or ☐n/a

Hematocrit:_____% OR Hemoglobin:_____gm/dl

- ☐ 1 - Within normal range
- ☐ 2 - >90th percentile (_____%ile)

	Normal	Abnormal
Vision/Eyes	☐	☐
HEENT	☐	☐
Dental (0-2 yrs. = scrng)	☐	☐
Lungs	☐	☐
Cardiac	☐	☐
Abdomen	☐	☐
Neurological	☐	☐
Back/Extremities	☐	☐
Genital	☐	☐
Skin	☐	☐

☐ Dental Referral made

If yes:

Dentist

Health Care Professional's Certification

I certify that the information on this form is accurate and complete to the best of my knowledge.

Provider's Name:_____ Date:_____

Provider's Signature:_____

Practice/Clinic Name:_____

Practice/Clinic Address:_____ City, State & Zip_____

Practice Phone:_____ Fax:_____

Provider Stamp Here