ALAMEDA HEAD START/EARLY HEAD START PROGRAM
Phone: (510) 629-6350 Fax: (510) 865-1930

Dear Medical Provider,

As a program we are mandated by the Federal Government to ensure that each child enrolled has a complete **PHYSICAL EXAM** in accordance with the **CA-EPSDT SCHEDULE**, and must be up-to-date on their I**MMUNIZATIONS**.

Please transcribe the results from the child's most recent physical exam onto the attached **MEDICAL EXAM REPORT.** The child must have a complete physical exam conducted by their primary care physician, and must include the following screenings, tests, and assessments:

- **Growth**
- **Blood Pressure**
- **Urine**
- **Vision**
- **Hearing**
- **Dental**
- **HGB/HTC**
- **TB Risk Factors**
- **Lead Blood Test**

If documentation is not provided, the child will need to return to your office for a follow-up appointment and/or referral.

Also, please note any concerns related to the following:

- **Speech and Language**
- **Behavioral**
- **Developmental**
- **Mental Health**

Thank you for assisting us in ensuring the ongoing health and overall well-being of the children enrolled in our program.

Sincerely,
Alameda Head Start
(510) 629-6350

Alameda Head Start/Early Head Start

MEDICAL EXAM REPORT

PATIENT: _____DOB: _____DATE OF EXAM: _____

Payment: ☐ **MEDI-CAL** ☐ **CHDP** ☐ **HEALTHY FAMILIES** ☐ **PRIVATE INSURANCE** ☐ **SELF PAID**

Required EPSDT Evaluations

☐ PHYSICAL EXAM ☐ DENTAL ASSESSMENT
☐ NUTRITIONAL ASSESSMENT
☐ DEVELOPMENTAL/BEHAVIORAL ASSESSMENT
☐ TOBACCO ASSESSMENT
☐ ANTICIPATORY GUIDANCE PROVIDED

Child's Health History

☐ NO CONCERNS ☐ Asthma _____
☐ Seizures _____ ☐ Neurological _____
☐ Sickle Cell _____ ☐ Orthopedic _____
☐ Other _____
☐ Allergies_____

Test Results and Procedures

(Due at age 7-9 months & annually after 12 months)
HGB HCT_____ _____ ANEMIC ☐YES ☐NO
Date Results

URINALYSIS: _____ _____
Date Results

BLOOD PRESSURE: _____ _____/_____
Date Results

☐ LEAD ASSESSMENT
LEAD BLOOD TEST (☐12 Month ☐ ≥ 24 Month)
_____ _____
Date Results

Measurements & Sensory Screenings

HEIGHT: _____n/cm WEIGHT: _____lbs/kg
HEAD CIRCUMFERENCE: _____in/cm **(ages < 24)**

AGES 0-3
VISION SCREENING: ☐ no concerns ☐ concerns
HEARING SCREENING: ☐ no concerns ☐ concerns

AGES 3-5	Pass	Referred to	Retest date
VISION:	_____	_____	_____
HEARING:	_____	_____	_____

IMMUNIZATION DATES

DPT/DTAP	1st	2nd	3rd	4th	5th
POLIO	1st	2nd	3rd	4th	5th
HIB	1st	2nd	3rd	4th	
MMR	1st	2nd		**VARICELLA**	1st
HEPB	1st	2nd	3rd	4th	5th
OTHER					

☐ **TB RISK ASSESSMENT: TB RISK FACTORS NOT PRESENT – TB TEST NOT RECOMMENDED AT THIS TIME**

☐ **PPD/MANTOUX** ☐ **XRAY TUBERCULIN TEST**: Date Given: _____ Result_____

Significant Family History Comments, Problems and Follow-Up:

Please note any concerns including speech/language and behavioral. (Use additional page if needed.)

REFERRAL: _____ PHONE: _____

Physician's Name: _____**Physician's Signature**: _____

Address: _____**Phone:** _____

I consider this Doctor/Medical Clinic to be my child's primary medical care provider: ☐ **YES** ☐ **NO**

I authorize Head Start/Early Head Start staff and the Physician/Clinic listed to exchange information related to this medical exam while my child is enrolled in the Head Start/Early Head Start program.

Parent's Signature: _____**Date**_____