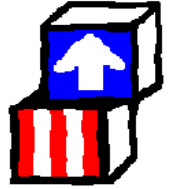


ALAMEDA HEAD START/EARLY HEAD START PROGRAM
Phone: (510) 629-6350 Fax: (510) 865-1930



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-EPSTD SCHEDULE**, and must be up-to-date on their **IMMUNIZATIONS**.

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: MEDICAL 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: _____