Wayne Metro Early Childhood Services
Early Head Start Health Appraisal

Child's Name _____ **Birthdate:** _____ ☐ **Male** ☐ **Female** **Today's Date:** _____

Parent/ Guardian Name _____ **Phone (H)** _____ **Phone (cell)** _____

Please check EPSDT Well Child Exam:

☐ 1 month ☐ 2 months ☐ 4 months ☐ 6 months ☐ 9 months ☐ 12 months ☐ 15 months
☐ 18 months ☐ 24 months ☐ 30 months

The U.S. Dept. of Health & Human Services requires the physical examination meet the Michigan Medicaid EPSDT requirements & MUST be completed by the Physician or Health Care Provider.

Date of Well Baby/Physical Examination _____

Required Tests	
Height:	**Weight:**
Head Circumference: 1 mo. – 24 mos.	inches
Vision: ☐ Normal ☐ Under Care ☐ Referred	
Hearing: ☐ Normal ☐ Under Care ☐ Referred	
Immunizations: ☐ Complete ☐ Up-To-Date ☐ Incomplete	
Attached Immunization Record to this Form.	

Required Tests
Hemoglobin at 12 months - Lead at 12 and 24 months
Hemoglobin: Date: Result:
☐ Normal ☐ Anemia ☐ Under Care
Lead: Date: Result:
☐ Normal ☐ Under Care
Sickle Cell: ☐ Negative ☐ Trait ☐ Positive ☐ Under Care

	Normal for age	**Describe Findings**
General appearance		
Posture, Gait		
Skin		
Head		
Eyes/Red Reflex		
Fixes/follows with eyes		
Ears: external & inner		
Responds to sound		
Nose, Mouth, Pharynx		
Teeth		
Speech		
Heart & Lungs		
Abdomen		
Genitalia		
Bones, Joints, Muscles		
Neurological		
Glands		
Muscular Coordination		
Allergies (List)		

Findings/Diagnosis/Restrictions/Chronic Conditions & Date Diagnosed	**Treatment Plan/Follow-up/Referrals**

This Well-Baby/Physical examination completed according to EPSDT schedule _____ Initial

PHYSICIAN SIGNATURE: _____ **Date:** _____ **Phone:** _____

Physician Name & Address (please print)_____ FAX: _____

Date form received in center: _____