PROJECT high five
WAYNE METRO EARLY CHILDHOOD SERVICES
Begin Healthy
Connect to Resources
Engage in Learning
Build Confidence
Thrive by Five

Wayne Metro Early Childhood Services
Head Start Health Appraisal

Child's Name: _____ Sex: _____ **Date of Birth:** _____
LAST FIRST MIDDLE

Parent/Guardian Name: _____ **Head Start Center:** _____

All information below is required by the Department of Health & Human Services–Head Start and recommended by the American Academy of Pediatrics. Please provide an explanation on all tests done, suspected or atypical results and reasons services were not performed.

HEAD START USE ONLY

REQUIRED TESTS AND EXAMINATIONS

TEST	TYPE OF TEST OR EXAM
A. Immunizations up to date? ☐ **Yes** ☐ **No** *(Please attach current record to this sheet)*	**BLOOD PRESSURE:** _____ **Ht.** _____ in. **Wt.** _____ lbs
RESULTS	**Vision Objective:** ☐ Normal ☐ Ocular Muscle ☐ Visual Activity ☐ Under Care ☐ Wears Glasses
List Immunizations Needed, if any:	**Hearing Objective:** ☐ Normal ☐ Audiometer ☐ Under Care ☐ Other
	(must be 2 years of age) (must have numerical value) **Hemoglobin:** _____ gm ☐ Normal ☐ Anemia ☐ Under Care **Lead:** _____ **Pb**
PHYSICAL FINDINGS	**Urinalysis:** ☐ Normal ☐ Under Care **Sickle Cell:** ☐ Not Applicable ☐ Negative ☐ Positive ☐ Trait

Please indicate findings below using codes:
Normal (N) **Abnormal (A)**
Needs follow-up (NFU)

Skin		
Eyes		**Findings/Diagnosis/Restrictions due to defect or illness?**
Ears		If yes, check below and explain degree of restriction:
Nose, Throat		☐ Classroom ☐ Playground/Gym ☐ Other
Mouth, Teeth		
Heart & Lungs		
Speech		
Abdomen		
Bones, Joints, Muscle Coordination		
Neurological, Gross, Fine Motor		

The Head Start physical exam **must** meet the Michigan EPSDT requirements as mandated by the U.S. Department of Health and Human Services Performance Standards. Please **complete** the attached form, **including** the required lab tests and examinations.

Parents will be required to return to your office with incomplete forms to have them completed

_____ _____/_____/_____ Phone #: _____
Physician's Signature **Date** Fax #: _____

_____
Physicians Name and Address *(Please Print)*

Staff Signature and Date Form Received in Center: _____

Examiner's Name & Address (Stamp)