UCCAC Early/Head Start Well-Child & Physical Exam Record

Main Office Fax# (845) 331-0270

UCCAC Office Use Only

Date Received: ________

Signature: ____________

Please Check: ___ **Well Child Visit** or ___ **Annual Physical**	**Date of Exam:**
Please Indicate: ________ Month Visit __________ Year Visit	____________

Part 1: Child's Personal Information

Child Name ____________________ Date of Birth ____________________ Parent/Guardian Name ______________________________

Part 2: Required Provider Certification and Signature

To the best of my knowledge, this child is free from communicable disease and free to participate in all program related activities. ☐ Yes ☐ No

SIGNATURE OF EXAMINER　DATE　ADDRESS, CITY, STATE & ZIP　STAMP

NAME (PLEASE PRINT) AND TITLE　PHONE NUMBER

Part 3: Child Health History, Examination, Results and Recommendations (**Please Provide MOST RECENT RESULTS for below**)

Head Circumference (<3 yrs)	Most Recent Blood Pressure (>3 yrs)	Most Recent Hct/Hgb reading	Height Weight ☐ Nrml
________ inches	Date: ________ Result: ________	Date: ________ Result: ______	______ ______ ☐ Abnl

Part 4: Tuberculosis and Lead Exposure Risk Assessment and Testing (**Please Provide MOST RECENT RESULTS for below**)

TB Exposure Risk? ☐ High Risk ☐ Low Risk　Last PPD Date: ____________

Lead Exposure Risk? ☐ High Risk ☐ Low Risk　Last Test Date: ____________ Most Recent Result: __________

Health Concerns:			**Health Concerns:**		
Dental-Oral Health	☐ None ☐ Yes	☐ Referred ☐ Under Tx	**Language**	☐ None ☐ Yes	☐ Referred ☐ Under Tx
Development	☐ None ☐ Yes	☐ Referred ☐ Under Tx	**Birth Marks**	☐ None ☐ Yes	**Location:** ____________
Behavioral/Emotional	☐ None ☐ Yes	☐ Referred ☐ Under Tx	**Vision**	☐ None ☐ Yes	**Most Recent Result:** ______
Learning/Attention	☐ None ☐ Yes	☐ Referred ☐ Under Tx	**Hearing**	☐ None ☐ Yes	**Most Recent Result:** ______

Part 6: Significant allergies or health condition that may require medication, special treatment, accommodations or emergency care at school? **(Program requires further medical documentation to be filled out if not already completed)**

☐ None　☐ Yes, please detail: ____

Child is receiving appropriate health care and age appropriate immunizations according to NYS EPSDT schedule for well care:
☐ **Yes** ☐ **No (if no explain:** ____________________**)**

Child is Up to Date on all Immunizations: (ATTACH RECORD)
☐ **yes** ☐ **No (if no explain:** ____________________**)**

**RISK FACTORS FOR TB IN CHILDREN:

- Have a family member or contacts with a history of confirmed or suspected TB
- Are in foreign-born families and from high-prevalence countries (Asia, Africa, Central and South America)
- Live in out-of-home placements
- Have, or are suspected to have, HIV infection
- Live with an adult with HIV seropositivity
- Live with an adult who has been incarcerated in the last five years
- Live among, or are frequently exposed to, individuals who are homeless, migrant farm workers, users of street drugs, or residents in nursing homes
- Have abnormalities on chest X-ray suggestive of TB
- Have clinical evidence of TB

Consult with your local health department's TB control program on any aspects of TB prevention and treatment

TO BE COMPLETED BY HEAD START STAFF

NAME OF STAFF COMPLETING 1ST REVIEW	SIGNATURE	POSITION	DATE
NAME OF STAFF COMPLETING 2ND REVIEW	SIGNATURE	POSITION	DATE

Referred for Follow-Up to:

HEALTH	MENTAL HEALTH	DISABILITIES	FAMILY SERVICES	EDUCATION	NUTRITION

Head Start Follow-Up & Notes

RECEIVED BY (PRINT NAME)	DATE RECEIVED