# CAO Well Child Care Exam

## **..! Information on this form is considered CONFIDENTIAL and must not be disclosed without proper authority!..**

## **Child’s Name** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **DOB**\_\_\_\_/\_\_\_\_/\_\_\_\_ **Gender** M F **Date of Exam** \_\_\_\_/\_\_\_\_/\_\_\_\_

Examiner: Please complete age-appropriate screenings and assessments (current and retrospective) per AAP guidelines. Thank you!

**Allergies**: NKA YES…Specify

**Medications**: NO YES…Specify

**Acute or Chronic Illnesses**: NO YES

Most Recent Occurrence \_\_\_\_/\_\_\_\_/\_\_\_\_

Details:

**Behavioral Concerns:**

###### Head Circ (Infant) \_\_\_\_\_\_\_\_\_\_\_\_

###### BMI \_\_\_\_\_\_\_\_\_\_\_\_

###### Height \_\_\_\_\_\_\_\_\_\_\_\_

###### Weight \_\_\_\_\_\_\_\_\_\_\_\_lbs.

**Blood Pressure \_\_\_\_\_\_\_\_\_\_\_\_**mm Hg

**Screenings and Risk Assessments**

**Lead Blood Level**:  **Tx Needed:…….**

**Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (within one year) Level \_\_\_\_\_\_ mcg/dl Yes No**

**Result: Normal Abnormal**

**Blood Count**: **Tx Needed:…..…**

###### HCT\_\_\_\_\_\_\_\_\_\_\_\_ % *or* HGB\_\_\_\_\_\_\_\_\_\_\_\_g/l Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Yes No

**Sickle Cell Risk Screening:** **Tx Needed:**

** Performed at birth Yes No**

** Performed Result: Normal Abnormal…Specify:  Disease  Trait**

**Other**: **Tx Needed:…..…**

**Type\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Result: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Yes No**

**TB Risk Assessment:** □ **No Risk Factors** □ **Risk Factors Present**

**A person is considered to be at high risk for TB (tuberculosis infection) if he/she can answer yes to one or more of the following:**

**\* Contacts with individuals who have infectious tuberculosis**

**\* Children who are born outside of the United States**

**\* Children determined to have abnormal chest x-rays related to signs of TB**

**\* HIV infected children**

**\* Children with low immune systems**

**\* Children with medical risk factors: Hodgkin’s disease, Lymphoma, Diabetes Mellitus**

**Chronic Renal Failure, Malnutrition**

**\* Children frequently exposed to adults that are HIV infected, homeless, residents of nursing homes,**

**Migrant farm workers**

|  |  |  |  |
| --- | --- | --- | --- |
|  | Normal | Abnormal | Referred |
| General Appearance |  |  |  |
| Posture, Gait |  |  |  |
| Speech |  |  |  |
| Head |  |  |  |
| Skin |  |  |  |
| Eyes External Aspect |  |  |  |
| Optic Fundoscopic |  |  |  |
| Cover Test |  |  |  |
| Ears External Canal |  |  |  |
| Nose, Mouth, Pharynx |  |  |  |
| Teeth / Gums |  |  |  |
| Heart |  |  |  |
| Lungs |  |  |  |
| Abdomen (include hernia) |  |  |  |
| Genitalia |  |  |  |
| Bones, Joints, Muscles |  |  |  |
| Neurological / Social |  |  |  |
| Gross Motor |  |  |  |
| Fine Motor |  |  |  |
| Communication Skills |  |  |  |
| Cognitive |  |  |  |
| Self-Help Skills |  |  |  |
| Social Skills |  |  |  |
| Glands (Lymphatic / Thyroid) |  |  |  |
| Muscular Coordination |  |  |  |
| Other |  |  |  |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| **Hearing: Treatment Needed:.** Yes No   |  |  |  | | --- | --- | --- | | **Tone (age ≥4)** | Right | Left | | 500 dB |  |  |  | | 1000 dB |  |  |  | | 2000 dB |  |  |  | | 4000 dB |  |  |  | | Gross (age<4) | Right | Left | | Normal |  |  | | Abnormal |  |  | |  |  |  | |  |  |  |   **Vision: Treatment Needed:. :.** Yes No   |  |  |  |  | | --- | --- | --- | --- | | **Acuity (age ≥3)** | Right | Left | Both | |  | 20/ | 20/ | 20/ |  | |  |  |  |  | | **Gross (age <3)** | Right | Left | Both | | Normal |  |  |  | | Abnormal |  |  |  |   **Strabismus: Treatment Needed: :.** Yes No   |  |  |  | | --- | --- | --- | |  | Right | Left | | Normal |  |  |  |  |  |  |  |  | | Abnormal |  |  |  |  |  |  | |

Immunization Record Attached (If not please complete grid below)

If child is not up to date, please indicate specific follow up dates under “Next Due”. OCFS licensing regulation 418.1-11(e)(1) requires Head Start to see evidence of specific follow up appointment dates before it may allow a child to enter program.

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Type | 1st | 2nd | 3rd | 4th | 5th | 6th | Next Due | Status | Exemption  med / relig | Serologic Immunity  Confirm Date |
| Hepatitis B |  |  |  |  |  |  |  |  |  |  |
| DtaP / DTP |  |  |  |  |  |  |  |  |  |  |
| Hib |  |  |  |  |  |  |  |  |  |  |
| Polio |  |  |  |  |  |  |  |  |  |  |
| MMR |  |  |  |  |  |  |  |  |  |  |
| Varicella |  |  |  |  |  |  |  |  |  |  |
| Pneumococcal |  |  |  |  |  |  |  |  |  |  |

**Based on information gathered during this examination, I find that this child currently appears to be free from contagious or communicable diseases, is receiving health care in accordance with the American Academy of Pediatrics schedule, and is able to attend child day care.**

**Signature of Examiner**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Print Name (or stamp)** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

###### Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Completed by** *(if different than Examiner)* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Date Form Completed** *(if different than Date of Exam)* \_\_\_\_/\_\_\_\_/\_\_\_\_ Revised January 2017