**Matrix Human Services Head Start Health Appraisal**

|  |  |  |
| --- | --- | --- |
| CHILD’S LAST NAME: **Duty**  FIRST NAME: **Howdie** | GENDER  ( F ) ( **M** ) | DATE OF BIRTH (mm/dd/yy)  **01/02/1234** |
| ADDRESS (Number & Street) (City) (ZIP Code)  **12345 Penny Lane**  **Wonderland**  MI **54321** | | HOME TELEPHONE NUMBER  (**123**)**345-6789** |
| PARENT/GUARDIAN (Last, First, Middle)  **Mouse , Mickey** | | WORK TELEPHONE NUMBER  (**123**)**543-9876** |
| I GIVE CONSENT FOR MY CHILD’S HEALTH CARE PROVIDER AND HEAD START TO DISCUSS THE INFORMATION ON THIS FORM **x**□ YES ⌧ □ NO | | |
| SIGNATURE **(REQUIRED**!)***Without parent’s signature you will not be able to call doctor to discuss information on form.*** | DATE **1-2-2013** | |

|  |
| --- |
| **IMMUNIZATIONS/ HEALTH HISTORY (This form should be completed by Health Care Provider)** |

□Immunization record attached □ No immunizations given today □ Immunizations up to date **Sickle Cell Screen:** □ Positive  **x**□ Negative □ Trait Date: **1/2/1234**

**One of the above boxes should be checked off. 90 day mandate (only 1 needed).🡼 Can take parent word if born in Michigan**

VACCINES WAIVED DUE TO REACTIONS/ CONTRADITICTIONS □ YES □ NO RELIGIOUS OBJECTIONS □ YES □ NO

**If applicable Health Care Provider should check box.** If applicable Health Care Provider should check box**.**

Does the child take any medication(s) regularly? **x**□ YES □ NO If yes, list medication(s): \_\_**Albuterol\_\_(Medication Dispensing form to be completed if medication is to be given onsite).**

Reason for medication(s) \_\_\_\_\_\_\_\_\_\_\_**Asthma\_**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Make Referral to Health** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Allergies:** □ Food □ Insect □ Environmental □ Seasonal □ other □ **LIFE THREATENING** (needs medication) Please state what child is allergic to and type of medication to be administered: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**NOTIFY THE NUTRITION COMPONENT**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |
| --- |
| **PHYSICAL EXAM** |

**To be done *annually* within the mandated timeframes \* see below**

**Date of Exam: \_*The date physical was done*. Height: 45 day mandate Weight: \_\_45 day mandate Blood Pressure: \_\_\_90 day mandate\_\_\_\_**

**\* If the needed screenings are incomplete and have not been done within in the past year, parents must have them completed and follow the mandated timeframe. Staff can not do the any of the screenings!**

|  |
| --- |
| Body Mass Index: **45 Day Requirement** **🡿** **Health Care Professional should complete this section**  Weight Status Category (BMI Percentile): Please check one:  □ less than 5th (Underweight) □ 5th \_84th (Healthy Weight) □ 85th - 94th  (Overweight) □ Greater than the 95th (Obese) |

|  |
| --- |
| **TESTS AND MEASUREMENTS** |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| No | Yes | Was child tested for: | **Vision & Hearing to be done within 45 days of entry unless performed within the last year. Required annually.**  Test results: | Normal | Referred | Under Care | No | Yes | Was child tested for: | Test results: | Normal  Referred | Referred | Under Care |
| □ | □ | **VISION**  Date: / / | Visual Acuity |  |  |  | □ | □ | HEMOGLOBIN / HEMATOCRIT**---Refer to Health&Nutrition when Hemoglobin is under 11 and/or Hematocrit is under 34** | **90 day Mandate. Acceptable if done within the last year. Required anually.**  Date: / / |  |  |  |
| Muscle imbalance |  |  |  |
| Other: |  |  |  |
| □ | □ | **HEARING**  Date: / / | Audiometer |  |  |  | □ | □ | Blood Lead Leve0263l  **Refer to Health when level is 5+**  Date: / / | **Only ONE required. Can be the 12 or 24 month screening. If missing, ONE must be done within 90 days of entry**.  Level ug/dl |  |  |  |
| Other: |  |  |  | **NOTE:** Blood lead level required for all children enrolled in Medicaid must be tested at one and two years of age, or once between three and six years of age if not previously tested. All children under age six living in high-risk areas should be tested at the same intervals as listed above. | | | | | | |
| □ | □ | Developmental / Behavioral Assessments:  **Date: / /** | Developmental Surveillance: |  |  |  |
| Psychosocial / Behavioral Assessment  **(Yearly Assessment)** |  |  |  |
|  |  |  |

**THE BOTTOM SECTION IS THE PHYSICAL EXAMANIATION AND MAY EXPIRE BEFORE OR AFTER LAB SCREENINGS (ABOVE). (SEE DATE OF PHYSICAL EXAM )**

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | **Normal** | **Under Care** | **Referred** |  | **Normal** | **Under Care** | **Referred** |  | **Normal** | **Under Care** | **Referral** |
| **Eyes** |  |  |  | **Lungs** |  |  |  | **Skin** |  |  |  |
| **Ear/Nose/**  **Throat** |  |  |  | **Breast** |  |  |  | **Extremities** |  |  |  |
| **Speech** |  |  |  | **Abdomen** |  |  |  | **Spine** |  |  |  |
| **Thyroid** |  |  |  | **Genitalia** |  |  |  | **General**  **Nutrition** |  |  |  |
| **Lymphatic**  **System** |  |  |  | **Developmental**  **Screening** |  |  |  | **Other** |  |  |  |
| **Heart/Vascular**  **System** |  |  |  | **Neurological**  **System** |  |  |  | **Other** |  |  |  |

|  |  |
| --- | --- |
| **EPSDT Health Care Up-to-Date/ Well Child (Please check) YES \_\_\_\_\_ NO \_\_\_\_\_ If physician checks NO we need to do whatever we can to help bring child up to date.**  **Essential Findings Deviating from Normal and Recommendations: Referral should be generated if applicable** | |
| **Examiner’s Name in Print \_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Examiner’s Signature \_\_\_\_\_\_\_\_\_\_\_\_\_ *Not valid without signature*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Office/ Clinic Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | **Telephone:** |
| **Medical Follow-Up Needed**  **Yes No**  **Referral should be made if applicable** |
| **Funded by The US Department of Health & Human Services** S:\1-Children'sServices\Health\FORMS\MatrixHumanServicesHead Start Health Appraisal 2013 2.doc | |