Matrix Head Start Health Appraisal

CHILD'S LAST NAME:	FIRST NAME:	GENDER (F) (M)	DATE OF BIRTH (mm/dd/yy) / /
ADDRESS (Number & Street)	(City) MI	(ZIP Code)	HOME TELEPHONE NUMBER ( )
PARENT/GUARDIAN (Last, First, Middle)			WORK TELEPHONE NUMBER ( )
I GIVE CONSENT FOR MY CHILD'S HEALTH CARE PROVIDER AND HEAD START TO DISCUSS THE INFORMATION ON THIS FORM ☐ YES ☐ NO			
SIGNATURE		DATE	

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 ☐ Negative ☐ Trait Date:_____

Vaccines *waived* due to reactions/contraindications ☐ YES ☐ NO **Date *Contraindication Waiver* signed by physician:** _____

Does the child take any medication(s) regularly? ☐ YES ☐ NO If yes, list medication(s): _____

Reason for medication(s) _____

Allergies: ☐ Food ☐ Insect ☐ Environmental ☐ Seasonal ☐ Other ☐ **LIFE THREATENING** (needs medication) **Please state what child is allergic to and type of medication to be administered:** _____

PHYSICAL EXAM

Date of Exam: _____ **Height:** _____ **Weight:** _____ **Blood Pressure:** _____

Body Mass Index: _____ **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

Date child tested for:	Test results: Subjective Unacceptable	Normal	Referred	Under Care	Date child tested for:	Test results: Please insert numerical value.	Normal	Referred	Under Care
VISION Date:___/___/___	Visual Acuity				**HEMOGLOBIN/ HEMATOCRIT** Date:___/___/___	HGB Results_____ HCT Results_____			
	Muscle imbalance								
	Other:								
HEARING Date:___/___/___	Audiometer				**Blood Lead Level** Date:___/___/___	Level____ ug/dl			

	NORMAL	UNDER CARE	REFERRED		NORMAL	UNDER CARE	REFERRED		NORMAL	UNDER CARE	REFERRED
Posture/Gait				**Lungs**				**Skin**			
Head				**Genitalia**				**Teeth**			
Speech				**Abdomen**				**Back**			
Glands				**Bones/Joints/ Muscle**				**General Appearance**			
Nose				**Developmental Surveillance**				**Psychosocial/Behavioral Assessment**			
Heart				**Anticipatory Guidance**				**History Initial/ Interval**			

EPSDT Health Care Up-to-Date/ Well Child (Please check) YES _____ NO _____

Do you serve as the child's Medical Home? (Please check) YES _____ NO _____

Essential Findings Deviating from Normal and Recommendations:

Examiner's Name in Print _____ **Date** _____

Examiner's Signature _____

Office/ Clinic Address _____

Telephone:

Medical Follow-Up Needed Yes No