Well Child Check

Name: _____ DOB: ___/___/_____ Sex: _____ Race: _____

Parent's Name: _____

Head Start Center & Phone Number: _____ ( ) _____

Health History

Birth Weight: _____ Birth Length: _____

Illnesses: _____

_____

Hospitalization: _____ / _____ /_____ / _____ / _____ / _____

Explanation: _____

_____

Allergies: _____

Medications: _____

Accidents: _____

Examination	Month/Day/Year	Results
Hematocrit/HGB Elect * Required by OHS	____/____/____	_____
Developmental Assessment	____/____/____	_____
Height (plotted on growth chart)	____/____/____	_____
Weight (plotted on growth chart)	____/____/____	_____
BP/P/R* Required by OHS	____/____/____	_____
Vision	____/____/____	_____
Hearing	____/____/____	_____
General Appearance & Behavior	____/____/____	_____
Skin/Hair/Nails	____/____/____	_____

Well Child Check

Examination	Month/Day/Year	Results
Eyes-Perris/Red/Reflex	____/____/____	_____
Ears	____/____/____	_____
Nose	____/____/____	_____
Mouth/Teeth	____/____/____	_____
Throat	____/____/____	_____
Lymph Nodes	____/____/____	_____
Chest/Lungs	____/____/____	_____
Breast	____/____/____	_____
Heart	____/____/____	_____
Abdomen	____/____/____	_____
Genitalia	____/____/____	_____
Extremities	____/____/____	_____
Scoliosis	____/____/____	_____
Lead Screening* Required by OHS	____/____/____	_____

Follow-Up Treatment Plan:

_____

_____

_____

Comments:

_____

_____

_____

_____
Health Provider's Signature

DEVELOPMENTAL ASSESSMENT

2 ½ - 3 Years	Normal	Abnormal
Names 4 Pictures	□	□
Speech Half Understandable	□	□
Can Wash & Dry Hands	□	□
Tower of 6 Cubes	□	□
Throws Ball Overhand	□	□
3 - 3 ½ Years	Normal	Abnormal
Names Friend	□	□
Knows 2 Actions	□	□
Tower of 8 Cubes	□	□
Puts on T-Shirt	□	□
Broad Jump	□	□
Toilet Trained - Daytime	□	□
3 ½ - 4 Years	Normal	Abnormal
Thumb Wiggle	□	□
Knows 4 Actions	□	□
Counts 1 Block	□	□
Names 1 Color	□	□
Copies 0	□	□
Buttons Shirt	□	□
Balance Each Foot 2 Seconds	□	□
Use of 2 Objects	□	□
4 – 5 Years	Normal	Abnormal
Dress – No Help	□	□
Names 4 Colors	□	□
Draws Person – 3 Parts	□	□
Copies +	□	□
Comprehends Cold, Tired, Hungry (2 of 3)	□	□
Hops	□	□
Balance Each Foot, 4 Seconds	□	□
Understands 4 Prepositions	□	□
Brush Teeth, No Help	□	□

NATIONAL CENTER ON
Early Childhood National Centers
Early Childhood Health and Wellness

Head Start Oral Health Form—Children

Patient Information

Child's name _____ Date of birth _____ Parent's/guardian's name _____ Phone number _____

Address _____ City _____ State _____ Zip code _____

This practice is the child's dental home: ☐ Yes ○ No

Current Oral Health Status

Does the child have any teeth with untreated decay? ☐ Yes (decay) ○ No (decay free)

Does the child have any teeth that have previously been treated for decay, including fillings, crowns, or extractions? ☐ Yes ○ No

Are there treatment needs? ☐ Yes, urgent ○ Yes, not urgent ○ No treatment needs

Oral Health Care Services Delivered During Visit

Diagnostic/Preventive Services

Examination: ☐ Yes ○ No
X-rays: ☐ Yes ○ No
Risk assessment: ☐ Yes ○ No
Cleaning: ☐ Yes ○ No
Fluoride varnish: ☐ Yes ○ No
Dental sealants: ☐ Yes ○ No

Counseling/Anticipatory Guidance

☐ Yes ○ No

Referral to Specialty Care

☐ Yes ○ No

_____
(Please specify specialist)

Restorative/Emergency Care

Fillings: ☐ Yes ○ No
Crowns: ☐ Yes ○ No
Extractions: ☐ Yes ○ No
Emergency care: ☐ Yes ○ No

Other: _____
(Please specify)

Future Oral Health Care Services

All treatment completed: ☐ Yes ○ No Next recall date: _____ / _____ (month/year)

More appointments needed for treatment? ☐ Yes ○ No

If yes: Approximate number of appointments needed: _____ Next appointment: Date: _____ Time: _____

Additional Information for Parents, Head Start Staff, and Medical Providers

Oral Health Provider's Contact Information and Signature

Provider name *(please print)* _____ Phone number _____ Fax number _____

Practice name _____ Address _____

Provider signature _____ Date of service _____

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