

**NMCAA PROGRAM PHYSICAL SCREENING**

The purpose of this screening is to assess the physical and developmental health of children enrolling in a NMCAA Child and Family Development Program. This physical will determine if a child is able to participate in preschool programming or home visiting programs and for staff to support each child’s growth and school readiness.

**Health Care Provider:** Please complete all boxed screening components below with specific results.

Check the appropriate “[ ] is or [ ] is not” and sign.

Well Child Visits q2 Week q1 Month q2 Month q4 Month q 6 Month q9 Month q12 Month

 q15 Month q18 Month q 24 Month q 30 Month q3 Years q4 Years q5 Years

Child’s Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ q Male q Female

**PLEASE COMPLETE ALL OF THE REQUIRED EPSDT SCREENING COMPONENTS BELOW**

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| --- |
| **Height\_\_\_\_\_\_\_\_\_\_ Weight\_\_\_\_\_\_\_\_\_\_ BMI\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** **Head Circumference\_\_\_\_\_\_\_\_\_\_\_\_ Blood Pressure\_\_\_\_\_\_\_\_\_\_\_\_** (beginning at 24 months) (1-24 Months)**Results:** Normal Abnormal Comments: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |
| **Physical Inspection** q Normal q Concerns:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Oral Inspection** q Normal q Concerns: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ q Refer to DDS **Nutritional Assessment q** Normal q Suspect q Atypical q Not Performed **Hearing Exam was:** q Subjective q Objective q Pass q Fail q Comments:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Vision Exam was:** q Subjective q Objective q Pass q Fail q Comments:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Autism Spectrum Disorder** (18 and 24 months) q Normal q Concerns:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   |
| **BLOOD TESTS****Lead:** Required at 12 and 24 months. If child has not been tested at 24 months, must screen.**Hemoglobin:** Required at 12 months. If child has not been tested at 12 months, must screen. **Lead** Date Tested: \_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_ Results\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Hemoglobin** Date Tested: \_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_ Results\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Cholesterol Risk Assessment** q Normal q Abnormal q Not at Risk  |
| **Immunization Status:** q Up to Date q Shots given: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ q Shots needed:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |
| **Pease indicate if the child has been, or is being treated for any of the following:** |
| Asthma q Yes q NoAllergies q Yes q NoAnemia q Yes q NoDiabetes q Yes q NoSeizures q Yes q No  | Neurological Concerns q Yes q NoOrthopedic Concerns q Yes q NoDevelopmental Concerns q Yes q NoOther: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ q Yes q No |

Referrarals/Recommendations:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**HEALTH STATEMENT** - I have, on this date, screened this child in order to determine physical fitness

and/or apparent evidence of communicable disease. In my opinion this child **[ ] is [ ] is not** physically and emotionally able to participate in educational activities. If the child is not able to participate, please explain above.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

  **Health Provider Signature & Date Name of Providers Office**

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **Date of Exam Date of next exam**

Parent takes this form to physician and returns it in envelope provided.

12/21 HS R&H/CCSC/scan or copy the physical for DMT and the Teacher/Provider EHS R & H/FSS enter directly into CP and attach in CP P/HeadStart/Health/HeadStartProgramPhysical

 **FOR NMCAA OFFICE USE ONLY: Date Received \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Time and Mileage to Appointment \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**