Text

Description automatically generated

**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**

|  |  |
| --- | --- |
| **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:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| **Please indicate if the child has been or is being treated for any of the following:** | |
| Asthma q Yes q No  Allergies q Yes q No  Anemia q Yes q No  Diabetes q Yes q No  Seizures q Yes q No | Neurological Concerns q Yes q No  Orthopedic Concerns q Yes q No  Developmental Concerns q Yes q No  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 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 Provider’s Office**

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

**Date of Exam Date of Next Exam**

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

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

**Distribution:** 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