# 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 | ☐ 2 wk | ☐ 1 mo | ☐ 2 mo | ☐ 4 mo | ☐ 6 mo | ☐ 9 mo | ☐ 12 mo |
| | ☐ 15 mo | ☐ 18 mo | ☐ 24 mo | ☐ 30 mo | ☐ 36 mo | ☐ 4 yrs | ☐ 5 yrs |

Child's Name _____ Date of Birth _____ ☐ Male ☐ 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** ❑ Normal ❑ Concerns:_____

**Oral Inspection** ❑ Normal ❑ Concerns:_____ ❑ Refer to DDS

**Nutritional Assessment** ❑ Normal ❑ Suspect ❑ Atypical ❑ Not Performed

**Hearing** ❑ Pass ❑ Fail ❑ Subjective Exam ❑ Objective Exam ❑ Comments:_____

**Vision** ❑ Pass ❑ Fail ❑ Subjective Exam ❑ Objective Exam ❑ Comments:_____

**Autism Spectrum Disorder** (18 and 24 months) ❑ Normal ❑ 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** ❑ Normal ❑ Abnormal ❑ Not at Risk

| **Immunization Status:** | ❑ Up to Date | ❑ Shots given: | ❑ Shots needed: |
|---|---|---|---|

**Please indicate if the child has been, or is being treated for any of the following:**

| | | | |
|---|---|---|---|
| Asthma | ❑ Yes ❑ No | Orthopedic Concerns | ❑ Yes ❑ No |
| Allergies | ❑ Yes ❑ No | Developmental Concerns | ❑ Yes ❑ No |
| Anemia | ❑ Yes ❑ No | Diabetes | ❑ Yes ❑ No |
| Seizures | ❑ Yes ❑ No | Other: _____ | |
| Neurological Concerns | ❑ Yes ❑ No | | |

**Referrals/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** **Date of Exam** **Date of next exam**

Parent takes this form to physician and returns it in envelope provided.
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
2/21

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