New Hampshire Early Childhood Health Assessment Record

Part II: PHYSICAL EXAMINATION, SCREENING, AND MEDICAL CONDITIONS

To be completed by the child's primary health care provider—must be a licensed physician, nurse practitioner, or physician's assistant.

Name of Child/Student	Date of Assessment	PLEASE ATTACH COPY OF IMMUNIZATION RECORD
Birth Date	Date of Next Scheduled Assessment	

Physical Examination

WT	*(must be taken within 60 days for WIC)*	lb / kg	Body Mass Index (BMI) *(if ≥ 2 years)*	
HT	*(must be taken within 60 days for WIC)*	in / cm	☐ *5–84th % ile* ☐ *85–94th % ile*	☐ *< 5th % ile* ☐ *≥ 95th % ile*
HC	*(if ≤ 2 years)*	in / cm	BP *(if ≥ 3 years)* /	☐ Within normal range ☐ ≥ 95th % ile

	Normal Yes	Normal No	Follow-up Indicated
HEENT	☐	☐	☐
Dental/Oral health	☐	☐	☐
Cardiac	☐	☐	☐
Lungs	☐	☐	☐
Abdomen	☐	☐	☐
Back/Extremities	☐	☐	☐
Breasts/Genitalia	☐	☐	☐
Neurologic	☐	☐	☐
Skin	☐	☐	☐

Please comment on any findings outside of normal range, including timeframe for re-evaluation, if applicable:

Preventive Screening

HEARING

PLEASE NOTE: Objective hearing screening beginning at age 4 years is REQUIRED for Head Start

Date performed: / / L ☐ Pass ☐ Fail R ☐ Pass ☐ Fail *Method:* ☐ Audiometry ☐ OAE

Was child referred for rescreen or further evaluation? Y ☐ N ☐ Does child wear a hearing aid? Y ☐ N ☐

VISION

PLEASE NOTE: Objective vision screening beginning at age 3 years is REQUIRED for Head Start

Date performed: / / L 20/ R 20/ Both 20/ *Method:* ☐ Snellen ☐ Tumbling E ☐ Other

Was child referred for rescreen or further evaluation? Y ☐ N ☐ Does child wear glasses? Y ☐ N ☐

LABS

PLEASE NOTE: Hgb or HCT values at ages 1 and 2 years, and lead levels at ages 1, 2, and 3-6 years are REQUIRED for Head Start

HGB:	g/dL	HCT:	%	Date: / /
HGB:	g/dL	HCT:	%	Date: / /
Lead:		mcg/dL		Date: / /
Lead:		mcg/dL		Date: / /
Lead:		mcg/dL		Date: / /

Is child at risk for TB? N ☐ Y ☐

If yes, PPD result: POS / NEG Date: / /

DEVELOPMENTAL SCREENING *(e.g., ASQ, ASQ:SE, M-CHAT, PEDS)*

Date of screening: / /

Screening tool(s) used:

Typically developing:	Y	N	Referred
Gross motor	☐	☐	☐
Fine motor	☐	☐	☐
Language/communication	☐	☐	☐
Problem-solving	☐	☐	☐
Social/emotional	☐	☐	☐

Special Needs

Chronic medical conditions/related surgeries?	☐ No ☐ Yes ☐ Special care plan attached*	*List special needs/considerations and medications below (other than in attached special care plans). Please attach Special Meals Prescription Form, if applicable.*
Medications or treatments?	☐ No ☐ Yes ☐ Special care plan attached*	
Allergies/sensitivities?	☐ No ☐ Yes ☐ Special care plan attached*	
Behavioral issues/mental health diagnoses?	☐ No ☐ Yes ☐ Special care plan attached*	
Limitations to physical activity?	☐ No ☐ Yes ☐ Special care plan attached*	
Special equipment needs?	☐ No ☐ Yes ☐ Special care plan attached*	
Special dietary requirements?	☐ No ☐ Yes ☐ Special care plan attached*	

Name, address, and telephone no. of primary health care provider *(please print or use stamp)*:

Signature of Primary Health Care Provider Date

**Please attach any special care plans or other information*