WELL-BABY CHECK-UP

Early Head Start

Circle One

6 weeks 2 Months 4 Months 6 Months 9Months 12 Months 18Months

Child's Name:_____

Date of Birth: __/__/__

Date of Well Baby Check __/__/__

Height: _____ Weight _____lbs. _____Ozs.

Head Circumference: _____

Hgb/Hct: _____ Vision Screening:_____

Hearing Screening: _____ Oral Health _____

Immunizations are up to date: YES NO

If no, plan to become up to date:_____

Immunizations received :_____

_____

Developmental Assessment:_____

_____

Recommendations/Referrals:_____

_____

_____ __/__/__

Physician's Signature Date

Note: Laboratory tests (including LEAD blood testing at 12 months)