WELL-BABY CHECK-UP

Early Head Start

Child's Name:____________________________ DOB: _____________________

Date of Well Child Check: _________________

Check WCC completed on this date:

☐ 6 weeks	☐ 4 Months	☐ 9 Months	☐ 15 Months
☐ 2 Months	☐ 6 Months	☐ 12 Months	☐ 18 Months

Height: ___________

Weight: ________lbs. ________oz.

Vision Screening: ( ) Within Normal Limits ( ) Refer

Hearing Screening: ( ) Within Normal Limits ( ) Refer

Oral Cavity Exam: ( ) Normal ( ) Abnormal, refer for further assessment

Hgb/Hct, completed at 12 month WCC: ( ) Yes, Results: ________ ( ) No

Lead Screening, completed at 12 month WCC: ( ) Yes Results: _______ ( ) No

Immunizations Received at this WCC:

Child's immunizations are up to date: ( ) Yes ( ) No If no, is a plan in place ( ) Yes ( ) No

_________________________________ _________________________________

_________________________________ _________________________________

_________________________________ _________________________________

Referrals/Recommendations:

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____________________________________ _________

Physician's Signature Date