Bradford-Tioga Head Start, Inc.
5 Riverside Plaza Blossburg, PA 16912

CHILD'S MEDICAL RECORD-(Please fill out form completely)

Child's Name:	**Date of birth:**
Exam Date:	**BTHS Service Area:**

IMMUNIZATION HISTORY (please provide dates or attach separate immunization log)

Polio					
DTaP					
MMR					
Hib					
Hep. B					
Varicella			**Had Virus**		
Hep. A					
Pneum.					
Other					

***Head Start requires that children have a record of Blood Lead Testing & Anemia Screening-(see back of this page)**

Anemia Screening	**Blood Lead Testing**	**Growth Measurements**	**Other Tests (if applicable)**
(Required at 9-12 months for EPSDT. Please document past results or complete this visit) **Hgb:_____gm/dL or Hct_____%** **Test date____/____/____**	**(Required at 9-12 months for EPSDT. Please document past results or complete this visit)** **BLL:_____ug/dL** **Test Date: ____/____/_____**	**Length/Height:_____in / cm** **Weight: _____lb / kg** **BMI:_____** **Head Circ.:_____in / cm**	**Urinalysis:_____** **Blood pressure:_____/_____** **Sickle Cell:_____** **Tuberculosis:_____**

PHYSICAL EXAM	**X=Normal**	**if abnormal, please comment**
Head/Ears/Eyes/Nose/Throat		
Teeth		
Cardio respiratory		
Abdomen/GI		
Genitalia/Breasts		
Extremities/Joints/Back/Chest		
Skin/Lymph Nodes		
Neurological & Developmental		
Allergies		

Sensory

		Norm.	Abn.
Vision:	**L**	___	___
	R	___	___
Hearing:	**L**	___	___
	R	___	___

Comments:

RECOMMENDATIONS

___ I recommend pre-medication for dental work.

___ I recommend a return/follow-up visit at this office in _____day(s) _____ weeks(s) _____ months(s)
Reason:

___ I recommend a referral to:
Reason:

HEALTH CARE PROVIDER PLEASE READ

IS CHILD UP-TO-DATE PER EPSDT SCHEDULE? YES_____ NO_____

SIGNATURE OF HEALTH CARE PROVIDER

Office Phone #:	**Name Printed:**
Date:	**Name Signed:**

Head Start references EPSDT as a standard of well child care and that Lead Screening for all children is required under EPSDT by the centers for Medicare and Medicaid Services. CMS requires that all children receive a screening blood Lead test at 12 months and 24 months of age. Children between the ages of 36 to 72 months must also have a Lead blood test if a Lead toxicity test has not been previously conducted.

In order for Head Start programs to meet and comply with Head Start Program Performance Standards, they must ensure that all children receive a Lead toxicity blood test.

Record of a Blood Lead test must be on the "Child's Medical Record". If a child has had a Blood Lead drawn in the past, please write the results on the form. If a Blood Lead has never been completed, then please complete one at this visit.