EARLY HEAD START WELL BABY CHECKUP
2 MONTHS

Child's Name:_____ Date of Birth: ____/____/____ PID#: _____

EXAMS COMPLETED DURING THE VISIT

- ❑ Hearing, Clinical Observation
- ❑ Vision, Clinical Observation
- ❑ TB Risk Assessment
  - □ Risk Factors not present; TB Skin Test not required
- ❑ TB Risk Factors present

  TB Skin Test performed (unless previous positive Skin Test documented)

  TB Test Date: _____ Date Read: _____
  - □ Communicable TB disease not present
- ❑ Oral Visual Exam
- ❑ Height: _____ in.
- ❑ Weight: _____ lb.
- ❑ Head Circumference _____

DEVELOPMENTAL MILESTONES

- ❑ Social smile (responsive)
- ❑ Follows past midline
- ❑ Follows parent with eyes
- ❑ Head raised to 45° when prone
- ❑ Grasps fingers
- ❑ Vocalizes

NUTRITION ASSESSMENT

Breast Milk: □ Yes □ No Formula: □ Yes □ No

Ounces/feeding: _____ Feedings/24 hrs: _____

Regular bowel movements: □ Yes □ No: _____

Feeding issues: □ No □ Yes: _____

IMMUNIZATIONS RECEIVED

- ❑ Polio 1 _____/_____/_____
- ❑ DTP 1 _____/_____/_____
- ❑ Hib 1 _____/_____/_____
- ❑ Hep B 1 _____/_____/_____
- ❑ Other: _____ _____/_____/_____

ANTICIPATORY GUIDANCE

- ❑ Car seat safety
- ❑ Burns, hot water temp 120° f
- ❑ Smoke detectors
- ❑ Immunizations risks
- ❑ Falls
- ❑ Second hand smoke

COMMENTS/CONCERNS:

4 MONTH APPOINTMENT SCHEDULED: _____ /_____ /_____

_____ _____ _____ / _____ / _____

Print Name of Doctor | Signature/ Official Stamped Signature | Exam Date

Phone: _____ Fax: _____

EHS Staff Only

Date Received:

____ / ____ / ____