



SUPPLEMENTAL HEALTH DATA



Child's Name: _____ DOB: _____

SCREENINGS COMPLETED BY HEAD START/EARLY HEAD START STAFF

VISION

Use HOTV chart only for vision screenings

Screening Date: <input type="checkbox"/> Uncooperative/Unable		Re-Screening Date: <input type="checkbox"/> Uncooperative/Refer	
Person/Agency Performing Screening:		Person/Agency Performing Screening:	
Was child screened with glasses on? <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> N/A		Was child screened with glasses on? <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> N/A	
Left Eye: <input type="checkbox"/> Pass <input type="checkbox"/> Fail	Right Eye: <input type="checkbox"/> Pass <input type="checkbox"/> Fail	Left Eye: <input type="checkbox"/> Pass <input type="checkbox"/> Fail	Right Eye: <input type="checkbox"/> Pass <input type="checkbox"/> Fail

HEARING

A check mark [✓] means that the child responded at 25dB. An X mark [X] means that the child did not respond at 25dB.

Screening Date: <input type="checkbox"/> OAE Machine				Re-Screening Date: <input type="checkbox"/> OAE Machine					
Person/Agency Performing Screening:				Person/Agency Performing Screening:					
Date Audiometer/OAE was Calibrated:				Date Audiometer/OAE was Calibrated:					
Right Ear	<input type="checkbox"/> 1000	<input type="checkbox"/> 2000	<input type="checkbox"/> 3000	<input type="checkbox"/> 4000	Right Ear	<input type="checkbox"/> 1000	<input type="checkbox"/> 2000	<input type="checkbox"/> 3000	<input type="checkbox"/> 4000
Left Ear	<input type="checkbox"/> 1000	<input type="checkbox"/> 2000	<input type="checkbox"/> 3000	<input type="checkbox"/> 4000	Left Ear	<input type="checkbox"/> 1000	<input type="checkbox"/> 2000	<input type="checkbox"/> 3000	<input type="checkbox"/> 4000
Was child screened with hearing aid on? <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> N/A				Was child screened with hearing aid on? <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> N/A					
Result: <input type="checkbox"/> Pass <input type="checkbox"/> Fail <input type="checkbox"/> Uncooperative/Unable				Result: <input type="checkbox"/> Pass <input type="checkbox"/> Fail <input type="checkbox"/> Uncooperative/Refer					

1st HEIGHT AND WEIGHT

2nd HEIGHT AND WEIGHT (completed 6months after first ht/wt)

Screening Date: _____	Screening Date: _____
Screening Result: Height: _____ in. Weight: _____ lbs.	Screening Result: Height: _____ in. Weight: _____ lbs.
BMI-HS / Weight for Length-EHS: _____ %	BMI-HS / Weight for Length-EHS: _____ %
Results: <input type="checkbox"/> Follow Up Needed* BMI/Weight for Length over 85 th % or under 5 th % <input type="checkbox"/> No Follow Up Needed BMI/Weight for Length within 5 th % - 85 th % Date of direct service: _____	Results: <input type="checkbox"/> Follow Up Needed* BMI/Weight for Length over 85 th % or under 5 th % <input type="checkbox"/> No Follow Up Needed BMI/Weight for Length within 5 th % - 85 th % Date of direct service: _____
Measurements Taken By: _____	Measurements Taken By: _____

*Follow up includes an internal or external referral and/or a direct service (done no later than 30 days after measurement)

SUPPLEMENTAL DOCUMENTATION FOR PHYSICAL EXAM

To be utilized ONLY if the information below was not recorded on the Physical Examination Form

HEMOGLOBIN/HEMATOCRIT (Need either a Risk Assessment answering 'No Risk' or blood test for Hgb or Hct)

Risk Assess.: Date: _____ Result: <input type="checkbox"/> At Risk <input type="checkbox"/> No Risk	Blood Test: Date: _____ Result Value: _____
Source of Information: _____	Source of Information: _____
Information Recorded By: _____	Information Recorded By: _____

BLOOD PRESSURE	LEAD	TB	Head Circumference
Screening Date: _____	Screening Date: _____	Circle one: Skin Test Blood Test	Screening Date: _____
Result: _____	Result: _____	Screening Date: _____	Result: _____
Source of Information: _____	Source of Information: _____	Result: _____	Source of Information: _____
Information Recorded By: _____	Information Recorded By: _____	Source of Information: _____	Information Recorded By: _____

COMMENTS/FOLLOW-UP: _____