EARLY HEAD START WELL BABY CHECKUP
6 MONTHS

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

EXAMS COMPLETED DURING THE VISIT

- ❑ Hearing, Clinical Observation
- ❑ Vision, Clinical Observation
- ❑ Lead Risk Assessment
- ❑ 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

- ❑ "Talks" to toys
- ❑ Turns to vocalized sounds
- ❑ Reaches for objects
- ❑ Transfers objects from hand to hand
- ❑ Sits briefly, leaning forward
- ❑ Rolls over two ways

NUTRITION ASSESSMENT

Breast Milk: ☐ Yes ☐ No Formula: ☐ Yes ☐ No

Ounces/feeding: _____ Feedings/24 hrs: _____

Juice: ☐ No ☐ Yes: _____

Regular bowel movements: ☐ Yes ☐ No: _____

Feeding issues: ☐ No ☐ Yes: _____

Solid foods: ☐ No ☐ Yes: _____

IMMUNIZATIONS RECEIVED
(circle which dose was administered)

- ❑ Polio 1 2 _____/_____/_____
- ❑ DTP 1 2 3 _____/_____/_____
- ❑ Hib 1 2 _____/_____/_____
- ❑ Hep B 1 2 _____/_____/_____
- ❑ Other:_____ _____/_____/_____

ANTICIPATORY GUIDANCE

- ❑ Falls – stairs / gates, walkers, furniture
- ❑ Burns – hot surfaces & liquids, kitchen safety
- ❑ Poison – poison center phone #
- ❑ Storage of drugs & household toxins safety sheet given
- ❑ Second hand smoke

COMMENTS/CONCERNS:

9 MONTH APPOINTMENT SCHEDULED: _____ /_____ /_____

_____ Print Name of Doctor

_____ Signature/ Official Stamped Signature

_____ / _____ / _____ Exam Date

Phone: _____ Fax: _____

EHS Staff Only

Date Received:

____ / ____ / ____