HEAD START, INC.

BILLINGS
615 N. 19th Street
Billings, MT 59101

Ph: (406) 869-1226
Fax: (406)245-1260

LAUREL
410 Colorado Ave.
Laurel, MT 59044

Ph: (406) 628-5870
Fax: (406) 628-5870

LOCKWOOD
1932 Hwy 87 E.
Billings, MT 59101

Ph: (406) 867-6224
Fax: (406) 867-6222

WELL CHILD CHECK UP - PHYSICAL

Health Care Provider: Please fax completed form to Head Start at 245-1260.

First Name		Last Name		M.I.	
Birth Date		Sex ☐ Male ☐ Female			
Health Care Provider's Name (Please Print):					
Address		Phone #		Room #	

The following assessments and tests are EPSDT requirements for Head Start.

Test	Not Indicated (NI)	Date	Result
HCT/HGB: mark NI or date given and result			
Blood Lead Test: mark NI if child was tested between the ages of 12 and 24 mos. or date given and result			
Blood Pressure			
Height			
Weight			

Assessment	Normal	Abnormal	No Eval.	Treatment or Prescriptions	Abnormal Findings
General Appearance					
Posture/Gait					
Speech					
Head					
Skin					
Nose, throat, pharynx					
Teeth					
Heart					
Lungs					
Abdoment					
Genitalia					
Neurological/social					
Glands					
Muscle Coordination					
Other					
Ears				**Hearing: Pure Tones _____ Impedance _____**	
Eyes				**Vision: Acuity R _____ L _____ B _____ Strabismus _____**	

Asthma inhaler needed at school? ☐ Yes ☐ No	Epi-pen needed at school? ☐ Yes ☐ No
Immunizations current? ☐ Yes ☐ No	Special diet needed? ☐ Yes ☐ No (If yes, include Special Diet Statement Form)
Immunizations given today:	Allergies:
Referrals/Recommendations:	
Signature:	**Date:**

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WELL CHILD CHECK UP – DENTAL

Dental Care Provider: Please fax completed form to Head Start at 245-1260.

First Name		Last Name		M.I.	
Birth Date		Sex ☐ Male ☐ Female			
Health Care Provider's Name (Please Print):					
Address		Phone #		Room #	

Description of Work and Services *(e.g. initial exam, x-rays, cleaning, treatment, etc.)*	**Date**

Results and Recommendations

☐ No Problems
☐ Cleaning/Fluoride
☐ Prescription for fluoride given to family
☐ Emphasize oral hygiene at home
☐ Treatment Needed *(Please specify number of each type needed)*:

_____ Sealants

_____ Restorations

_____ Pulp Therapy

_____ Extractions

_____ Approximate total number of visits needed to complete treatment

Is all treatment, excluding routine checkups, cleaning, and fluoride, complete? ☐ Yes ☐ No

Next scheduled Appointment:

Referrals/Recommendations:

Signature:	**Date:**