

Sure Start Child Health Screening

Date _____ Anticipated Enrollment Date _____
 Child's Name _____ Child's Date of Birth _____
 Child's Sponsor's Name _____ Spouse's Name _____
 Sponsor's Address _____ Spouse's Address _____

 Sponsor's Home Phone _____ Spouse's Home Phone _____
 Sponsor's Duty Phone _____ Spouse's Duty Phone _____
 Hospital/Clinic _____ Phone _____
 Doctor/Physician _____ Phone _____
 Dental/Clinic _____ Phone _____

Completed by School

Completed by School

	Speech/Language	Vision	Hearing	Develop/Screening
Date				
Type				
Pass/Fail				
Date				
Type				
Pass/Fail				

Immunization Record

	Date Received	Date Received	Date Received
DPT 2 (MOS)		TBT 12 (MOS)	DPT 4-6 (YRS)
OPV 2 (MOS)		OPV 15 (MOS)	OPV 4-6 (YRS)
DPT 4 (MOS)		DPT 15 (MOS)	MEAS 5-6 (YRS)
OPV 4 (MOS)		MMR 15 (MOS)	HEP (B) 1-4 (YRS)
DPT 6 (MOS)			OTHER
IIIB 2,4,6 (MOS)			

Physical Exam (must be completed within 45 days of enrollment)

Date of Exam _____ Clinic _____ Phone _____

Height _____

Weight _____

Medical Screenings

	TB	Lead	HGB/HCT	BP
Date				
Result				
Date				
Result				

Problem List

Date	Problem	(A) Active	(I) Interactive	(F) Follow-up Needed	(A-I-F)

Current medical treatment and prescribed medication:

Follow-up Needed = (X)

** TB and Lead screening is at the discretion of the physician

Dental Form

Date Dental Exam	X-Ray	Prophy	Flouride	Water (FW)	Tablet(FT)	Rinse (FR)

Dental Treatment

Date Dental Work	Problem	(C) Completed	(I) Incomplete	(F) Follow-up Needed	C-I-F

Diagnostic Code

Horizontal stripes indicate
Stainless Steel Crown
covering tooth entirely.



Solid Area indicates
filling present.



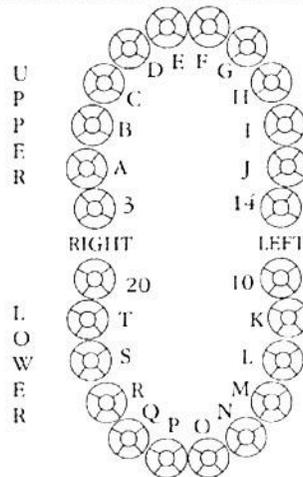
Zebra Stripes indicates
decay present.



Vertical Line indicates
to be extracted.



"X" indicates a missing tooth.



Medical and Dental Procedures

The above named child was examined by me and found to be in satisfactory health for participation in Sure Start. Examination results indicate that the child is apparently free from communicable disease and able to participate in all activities except as noted below.

Limitations: _____

Signature of Physician: _____ Date: _____
 Signature of Dentist: _____ Date: _____