

Immunization:	Record date of each dose received (mm/dd/yy)					*Required	**Recommended			
	1st	2nd	3rd	4th	5th		1st	2nd	3rd	4th
DPT (Diphtheria, pertussis, tetanus)*						MMR (Measles, Mumps, Rubella) *				
Td/DT *							HBV (Hepatitis B) **			
OPV or IPV (Polio) *						TB (Skin Test) *		Date	Result	

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PHYSICAL EXAMINATION: To be completed by health care provider approved to perform health assessments.

Height _____	Weight _____	Hgb or Hct _____
Pulse _____	Blood Pressure _____	Lead _____
Urinalysis _____	Sickle Cell _____	Other _____
Tuberculosis _____	Head Circumference _____	

Code Each Item as Follows: 0 = No significant findings 1 = Significant findings	Code	Description of Findings
General Appearance		
Integument		
Head - Neck		
EENT		
Oral - Dental		
Thorax		
Breasts		
Cardiovascular		
Abdomen		
Musculoskeletal		
Genitourinary		
Neurological		

SCREENING

1. Nutritional Evaluation (all ages - each screen) (✓ if applicable) Nutrition/WIC Questionnaires available from (785) 296-0092.
 Enrolled in WIC Receiving Vitamin Supplement with iron Without iron Fluoride Supplement

Food intake review. Results:
 milk/milk products (breast-fed/type of formula) _____
 fruit/vegetables _____
 meat, beans, eggs _____
 breads, cereals _____

Type of screen _____

2. Development _____ Results _____

3. Speech _____ Results _____

4. Hearing _____ Results _____ Date of last screen _____

5. Vision _____ Results _____ Date of last screen _____

<p><u>Significant Assessment Findings:</u></p> <p><u>Recommendations:</u> (include referrals)</p> <p><u>Follow Up:</u></p>	<p><u>Anticipatory Guidance:</u> (circle those discussed)</p> <table border="0"> <tr> <td>1. Safety/poisons</td> <td>8. Lifestyle</td> <td>9. Development</td> </tr> <tr> <td>2. Nutrition</td> <td>10. Behavior</td> <td></td> </tr> <tr> <td>3. Parenting</td> <td>11. Sexuality</td> <td></td> </tr> <tr> <td>4. Family Planning</td> <td>12. Dental</td> <td></td> </tr> <tr> <td>5. Discipline</td> <td>13. Other</td> <td></td> </tr> <tr> <td>6. Immunizations</td> <td></td> <td></td> </tr> <tr> <td>7. Hygiene</td> <td></td> <td></td> </tr> </table> <p><u>Comments:</u></p>	1. Safety/poisons	8. Lifestyle	9. Development	2. Nutrition	10. Behavior		3. Parenting	11. Sexuality		4. Family Planning	12. Dental		5. Discipline	13. Other		6. Immunizations			7. Hygiene		
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Additional Information may be attached

Signature of Licensed Physician or Nurse approved to perform health assessments. _____ Date _____