LSU Health NEW ORLEANS
School of Allied Health Professions
Human Development Center

Early Head Start Child Care Partnership

Medical Form

Dear Health Provider,
LSUHSC's Early Head Start is a federally funded child development program which strives to ensure that all enrolled children are up-to-date on medical and dental health screenings. We ask that you fill out the following information for the child named below who is enrolled in our program. We wish to act as partners with the health care community and parents to ensure preventative health care for children and their families. We appreciate your assistance is completing this form so that parents may return it to our program.

Please Complete All Requested Information

Child's Name: _____ DOB: _____

Date of well child physical exam _____ Results: _____

Medications required at school: _____ Allergies: _____

If child has a food allergy, what should be given as a substitute? _____

Illnesses/Conditions: (anemia, asthma, hearing difficulties, vision problems, high lead level, diabetes, other):

_____

Height: _____Weight: _____ Head Circumference: _____ Immunizations up to date? __ yes ___no

Hearing Screen-Type:___ R __ L __ Vision Screen-Type: _____ R __ L __ BP **(if older than 3)**_____

Hemoglobin/Hematocrit **(if older than 1)**: _____ Date: _____ TX: _____

Lead **(if older than 1)**: (Capillary/Venous) _____ Date: _____ TX: _____

Physical Examination/Assessment:

	Normal	Abnormal	Comments		Normal	Abnormal	Comments
General Appearance				Heart/Lungs			
Posture, Gait				Abdomen (Hernia)			
Speech				Genitalia			
Mouth/Teeth Dental/ Nutrition				Bones, joints, muscles			
Eyes				Muscular Coordination			
Ears/Nose/ Throat				Social/ Emotional			

Future Medical Care Services:

Do you consider this child up to date according to **LA EPSDT Periodicity Schedule**? ___YES ___ NO

When is this child due back for their **next well child visit**? _____

_____ _____ _____

Provider name (please print) Phone number Fax number

_____ _____

Practice name Address

_____ _____

Provider signature Date

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