The Learning Coalition

PHYSICAL / WELL CHILD EXAM

Child's Name: ____________________________________ **Sex:** _______ **Date of Birth:** _________ **Race:** __________

IMMUNIZATIONS (May also provide immunization record)		These screenings are required for the Medicaid EPSDT Program					
		VISION	**HEARING**	**BLOOD PRESSURE**	**HEIGHT**	**WEIGHT**	**Sickle Cell Trait?** YES ☐ NO ☐
VACCINE	**DATE**	DATE	DATE	Date:	Date:	Date:	**Sickle Cell Disease?**
DTaP	1	Acuity:	dB:	Reading:	Reading:	Reading:	YES ☐ NO ☐
	2	Strabismus:	Hz:	**Hemoglobin**	**Hematocrit**	**Lead Test**	**Sickle Cell Test**
	3	**TB RISK**		Date:	Date:	Date:	Date:
	4	YES ☐	NO ☐	Results:	Results:	Results:	Results:
POLIO	1	**NEONATAL HEARING**	**Responds to voice/noise/noisemaker?** YES ☐ NO ☐	**ALLERGIES:**			
	2						
	3						
	4						
VARICELLA	1	**NEONATAL VISION**	**Looks at faces/Fixes and follows?** YES ☐ NO ☐	**MEDICATIONS:**			
	2						
HepA	1						
	2						

EXAMINATIONS and/or INSPECTIONS

VACCINE	DATE		NORMAL	ABNORMAL	REFERRED	Findings deviating from normal and/or recommendations
HepB	1					
	2					
MMR	1	Eyes				
	2	Ears, Nose,Throat				
HIB	1	Teeth				
	2	Thyroid				
	3	Lymphatic System				
	4	Heart-Vascular Syst.				
PNE	1	Lungs				
	2	Breasts				
	3	Abdomen				
ROT	1	Genitalia				
	2	Neurological Syst.				
	3	Skin				
Influenza		Extremities				
Seasonal Flu Vaccine Not Available ☐		Spine				
		Speech/Language				

Is this child in suitable condition for enrollment? **YES** ☐ **NO** ☐

Physician / Examiner's Name: ____ **Today's Date:**________________

Physician / Examiner's Signature: ____ **Date of Examination:** _________________

Clinic Address: