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**NMCAA PROGRAM PHYSICAL SCREENING**

The purpose of this screening is to assess the physical and developmental health of children enrolling in a NMCAA Child and Family Development Program. This physical will determine if a child is able to participate in preschool programming or home visiting programs and for staff to support each child’s health and school readiness.

**Health Care Provider:** Please complete all boxed screening components below with specific results.

Check the appropriate “[ ] is or [ ] is not” and sign.

Child’s Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ q Male q Female

Program/Site Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Teacher/CFS \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Return to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Well Child Visits | q 2 Week | q 1 Month | q 2 Month | q 4 Month | q 6 Month | q 9 Month | q 12 Month |
|  | q 15 Month | q 18 Month | q 24 Month | q 30 Month | q 3 Years | q 4 Years | q 5 Years |

**PLEASE COMPLETE ALL OF THE REQUIRED EPSDT SCREENING COMPONENTS BELOW**

|  |  |
| --- | --- |
| **Height**\_\_\_\_\_\_\_\_ **Weight**\_\_\_\_\_\_\_\_ **BMI**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Head Circumference**\_\_\_\_\_\_\_ **Blood Pressure**\_\_\_\_\_\_\_\_\_\_\_\_  (beginning at 24 months) (1-24 Months) (beginning at age 3)  **Results: q** Normal q Abnormal Comments: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| **Physical Examination** q Normal q Concerns:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_    **Oral Inspection** q Normal q Topical fluoride treatment given q Concerns: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ q Refer to DDS    **Nutritional Assessment q** Normal q Suspect q Atypical q Not Performed    **Hearing Exam was:** q Pass q Fail q Refused Type of screening used:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Vision Exam was:** q Pass q Fail q Refused Type of screening used:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_    **Autism Spectrum Disorder** (18 and 24 months) q Normal q Concerns:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| **BLOOD TESTS**  **Lead:** Required at 12 and 24 months. If child has not been tested at 24 months, must screen.  **Hemoglobin:** Required at 12 months. If child has not been tested at 12 months, must screen.    **Lead** Date Tested: \_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_ Results\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_    **Hemoglobin** Date Tested: \_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_ Results\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Cholesterol Risk Assessment** q Normal q Abnormal q Not at Risk | |
| **Immunization Status:** q Up to Date q Shots Given: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ q Provisional q Incomplete q Waiver | |
| **Please indicate if the child has been or is being treated for any of the following:** | |
| |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | | ADHD | q Yes | q No | Hearing Problems | q Yes | q No | | Allergies\* | q Yes | q No | High Lead Level | q Yes | q No | | ASD | q Yes | q No | Seizures | q Yes | q No | | Asthma | q Yes | q No | Vision Problems | q Yes | q No | | Diabetes | q Yes | q No | \*Life threatening allergies (food, bee, medication) | | | | |  |  |  | | --- | --- | --- | | Neurological Concerns | q Yes | q No | | Orthopedic Concerns | q Yes | q No | | Developmental Concerns | q Yes | q No | | Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ | q Yes | q No | |

Referrarals/Recommendations:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**HEALTH STATEMENT** - I have, on this date, screened this child in order to determine physical fitness and/or apparent evidence of communicable disease. In my opinion this child **[ ] is [ ] is not** physically and emotionally able to participate in educational activities. If the child is not able to participate, please explain above.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Health Provider Signature & Date Name of Provider’s Office**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Date of Exam Date of Next Exam**

**FOR NMCAA OFFICE USE ONLY: Date Received \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Time and Mileage to Appointment \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Distribution:** HS R&H/CCSC: Scan or copy the physical for DMT and the Teacher/Provider EHS R&H/FSS: Enter directly into CP and attach in CP