Dear Healthcare Provider, Text

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We have received a copy of a Well Child Exam/Physical Screening for the child listed below. Due to the Michigan Department of Licensing and Regulatory Affairs, the health statement below must be completed for the child to participate in a preschool or home visiting program. **Please check the appropriate “[ ] is or [ ] is not” as well as sign and date the child's most recent Well Child Exam/Physical Screening.**

Thank you for your help.

**NMCAA Program Physical Screening Health Statement**

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 or a home visiting program and for staff to support each child’s health and school readiness.

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

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

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

**HEALTH STATEMENT**- I have, on this date, screened this child 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 Head Start. If the child is not able to participate, please explain below.

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

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

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

**Date of Exam Date of Next Exam**

Early Head Start, Head Start and GSRP Programs are directed by federal and state regulations

to meet EPSDT standards for health screening.

**Change location to Health on Weebly from ERSEA Selection/Acceptance**

**FOR NMCAA OFFICE USE ONLY: Date Received \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Time and Mileage to Appointment \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

R&H will send to Health Providers as needed for completion. A copy will be attached to the Child’s physical in the child’s file.

4/2023 EHS-HS Team/Admin/HeadStart/Health/NMCAA Program Physical Health Statement