218-999-0814
Fax: 218-999-0842
Headstartadmin@kootasca.org

822 NE 5th Ave
Grand Rapids, MN 55744
www.kootasca.org

KOOTASCA Head Start

Proudly Serving Communities: Greenway / Deer River / Grand Rapids / Northome / International Falls

Well Child

Physical Examination/Vision/Hearing Assessment

Revised 5/21/24

Child's Name	Gender ☐ Male ☐ Female	Date of Birth
Parent/Guardian Name	Date of Exam	
Medications		

Allergies/Reaction:
☐ No Known Diagnosed Allergies

Present Age		**Lab Tests**	**Date**	**Results**	Fluoride Varnish	☐ Done Today ☐ Done at Dentist ☐ Declined
Height		Hgb				
Weight		*Lead			Refer to Dentist *required ≥3 yr	☐ Has been seen in past 6months ☐ Referred
BMI		*Lead required @ 12 and 24 months or thru 6 yr, if never tested.				

Please address the following:

Physical Exam (include oral exam) ______________________________
Health Hx (include nutrition)______________________________
Mental Health/Behavior ______________________________
Anticipatory Guidance & Health Ed______________________________
Developmental Assessment (document screening tool if used)______________________________

IMMUNIZATIONS

☐ Up To Date ☐ Medical Exemption ☐ Conscientious Objection

☐ On Catch Up Plan-Please Provide Catch Up Timeline:

☐ Received Immunizations Today

HEARING SCREENING

Had NB hearing screening	☐ Yes	☐ No
Speech/Lang development WNL	☐ Yes	☐ No
Hearing history is significant	☐ Yes	☐ No

Circle risk factors which apply
Family Hx, Head Trauma, Serious Illness (ex. Meningitis), Hx middle ear disease/tubes

Puretone Screening (required 4 years and older)

Level	25	20	20	20
Frequency	500	1000	2000	4000
Right Ear				
Left Ear				

☐ Head Cold ☐ WNL ☐ Rescreen ☐ Refer

VISION SCREENING

Vision history is significant	☐ Yes	☐ No
Child wears glasses or contacts	☐ Yes	☐ No
Child wearing glasses/contacts when screened	☐ Yes	☐ No
External Inspection – WIPL	☐ Pass	☐ Rescreen
Observation (newborn & older)	☐ Pass	☐ Rescreen
Cover Test (6 months & older)	☐ Pass	☐ Rescreen
Corneal Light Reflection (6 months & older)	☐ Pass	☐ Rescreen

Visual Acuity (required 3 years and older)

Right Eye _____/__________.

Left Eye _____/__________.

☐ Pass ☐ Rescreen ☐ Refer

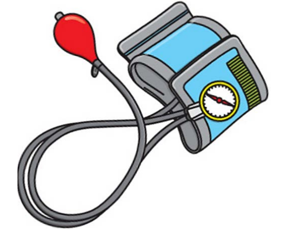
I certify the above work has been completed

Provider Name (please print)	Clinic Name	Address

Provider Signature

Phone

Preparing your child for a well-child exam with the doctor



Explain to your child what is going to be done at the doctor visit and answer any question they may have

Some items to explain to children include:

☺ The nurse will see how tall you are and how much you weigh so they can make sure you are growing well.

☺ They will check your eyes to test how well you see, and your ears to see how well you can hear.

☺ The doctor will look into your ears and listen to you breathe.

☺ The nurse will use an instrument that wraps around your arm and "gives it a hug."

☺ If your child is due for shots, explain to the child that it will be done really fast. DO NOT LIE AND SAY THAT IT WON'T HURT! Let them know that it will feel like a really fast pinch.

☺ The doctor may also have them march in place, stand on one foot, etc.

Teach your child that the doctor is their friend and that the doctor wants them to stay healthy.