St. Augustine Health Ministries

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? YES ☐ NO ☐
DTaP	1	Acuity:	dB:	Reading:	Reading:	Reading:	
	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						
HepB	1						
	2						
MMR	1						
	2						
HIB	1						
	2						
	3						
	4						
PNE	1						
	2						
	3						
ROT	1						
	2						
	3						
Influenza							
Seasonal Flu Vaccine Not Available ☐							

EXAMINATIONS and/or INSPECTIONS

	NORMAL	ABNORMAL	REFERRED	Findings deviating from normal and/or recommendations
Eyes				
Ears, Nose, Throat				
Teeth				
Thyroid				
Lymphatic System				
Heart-Vascular Syst.				
Lungs				
Breasts				
Abdomen				
Genitalia				
Neurological Syst.				
Skin				
Extremities				
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: