Dear Medical Provider,

As a program we are mandated by the Federal Government to ensure that each child enrolled has a complete PHYSICAL EXAM in accordance with the CA-EPSDT SCHEDULE, and must be up-to-date on their IMMUNIZATIONS.

Please transcribe the results from the child’s most recent physical exam onto the attached MEDICAL EXAM REPORT. The child must have a complete physical exam conducted by their primary care physician, and must include the following screenings, tests, and assessments:

- Growth
- Blood Pressure
- Urine
- Vision
- Hearing
- Dental
- HGB/HTC
- TB Risk Factors
- Lead Blood Test

If documentation is not provided, the child will need to return to your office for a follow-up appointment and/or referral.

Also, please note any concerns related to the following:

- Speech and Language
- Behavioral
- Developmental
- Mental Health

Thank you for assisting us in ensuring the ongoing health and overall well-being of the children enrolled in our program.

Sincerely,
Alameda Head Start
(510) 629-6350
Alameda Head Start/Early Head Start

MEDICAL EXAM REPORT

PATIENT: ___________________________________________ DOB: ___________ DATE OF EXAM: ___________

Payment: □ MEDI-CAL  □ CHDP  □ HEALTHY FAMILIES  □ PRIVATE INSURANCE  □ SELF PAID

Required EPSDT Evaluations

- □ PHYSICAL EXAM
- □ DENTAL ASSESSMENT
- □ NUTRITIONAL ASSESSMENT
- □ DEVELOPMENTAL/BEHAVIORAL ASSESSMENT
- □ TOBACCO ASSESSMENT
- □ ANTICIPATORY GUIDANCE PROVIDED

Child’s Health History

- □ NO CONCERNS
- □ Asthma ____________
- □ Seizures ____________
- □ Neurological ____________
- □ Sickle Cell ____________
- □ Orthopedic ____________
- □ Other ____________
- □ Allergies ____________

Test Results and Procedures

(Due at age 7-9 months & annually after 12 months)

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Date</th>
<th>Results</th>
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</thead>
<tbody>
<tr>
<td>HGB HCT</td>
<td></td>
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<tr>
<td>ANEMIC □YES □NO</td>
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<tr>
<td>URINALYSIS</td>
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<tr>
<td>BLOOD PRESSURE</td>
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</tbody>
</table>

- □ LEAD ASSESSMENT

LEAD BLOOD TEST ( □12 Month □ ≥ 24 Month)

<table>
<thead>
<tr>
<th>Date</th>
<th>Results</th>
</tr>
</thead>
</table>

Measurements & Sensory Screenings

- AGES 0-3
  - VISION SCREENING: □ no concerns □ concerns
  - HEARING SCREENING: □ no concerns □ concerns

- AGES 3-5
  - Pass
  - Referred to
  - Retest date

IMMUNIZATION DATES

<table>
<thead>
<tr>
<th>Vaccine</th>
<th>1st</th>
<th>2nd</th>
<th>3rd</th>
<th>4th</th>
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<td>HEPB</td>
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<tr>
<td>OTHER</td>
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- □ TB RISK ASSESSMENT: TB RISK FACTORS NOT PRESENT – TB TEST NOT RECOMMENDED AT THIS TIME

- □ PPD/MANTOUX □ XRAY TUBERCULIN TEST: Date Given: ___________________________ Result ___________________________

Significant Family History Comments, Problems and Follow-Up:

Please note any concerns including speech/language and behavioral. (Use additional page if needed.)

REFERRAL: ___________________________ PHONE: ___________________________

Physician’s Name: ___________________________ Physician’s Signature: ___________________________

Address: ___________________________ Phone: ___________________________

I consider this Doctor/Medical Clinic to be my child’s primary medical care provider: □ YES □ NO

I authorize Head Start/Early Head Start staff and the Physician/Clinic listed to exchange information related to this medical exam while my child is enrolled in the Head Start/Early Head Start program.

Parent’s Signature: ___________________________ Date ___________________________