CUMBERLAND COMMUNITY ACTION PROGRAM, INC., HEAD START
POB 2009
PHONE: 910-487-9992 **Fayetteville, NC 28302** **Fax: 910-868-3627**

Health Check – EPSDT (Early, Periodic, Screening, Diagnosis, & Treatment)

ALL of the following items must be included in the Health Check to meet our Funded Requirements for Enrollment
(Based on the Age of the child)
Schedule of periodicity: 2, 4, 6, 9, 12, 15, 18 months and 2, 3, 4 years old

Date of Assessment: _____

Child's Name: _____ Sex: M F DOB: _____

Head Start Center _____ Teacher: _____

Height: _____ Weight: _____ Blood Pressure: _____ Pulse: _____

Length (infant): _____ Head Circumference (infant): _____ Hgb/Hct:_____

TB Skin Test Results: _____ **Any Blood Lead Level results:** _____

Exam	Normal? (Circle One)	Abnormal Findings/Comments/Follow up/Referrals Required
Vision	Yes No	Glasses? Yes No
Hearing	Yes No	Hearing Device? Yes No
Developmental/Behavioral Assessment	Yes No	
General Appearance	Yes No	
Posture/Gait	Yes No	
Speech	Yes No	
Head	Yes No	
Eyes/Sclera/Pupils	Yes No	
Ears	Yes No	
Nose/Mouth/Throat	Yes No	
Teeth/Gums	Yes No	
Heart	Yes No	Murmur? Yes No
Lungs	Yes No	
Asthma - Please provide Asthma Action Plan	Yes No	Asthma Follow up evaluation needed: 3 months _____ 6 months _____
Abdomen	Yes No	Hernia? Yes No Repaired
Skin	Yes No	
Allergies	Yes No	
Any Restrictions or Special Needs	Yes No	

Anticipatory Guidance:

☐ Asthma Education ☐ Injury prevention ☐ Sleep positioning ☐ Other: _____
☐ Lead poisoning ☐ Violence prevention ☐ Nutritional Counseling

_____ _____
Health Care Provider Signature Date

_____ _____
Printed Health Care Provider Name Phone Number