Physical Exam—Infant/Toddler

Reach Dane
2096 Red Arrow Trail
Madison WI 53711
(608) 275-6740
(608) 275-6756 Fax

Parent/Guardian Name: _____ Program/FA: _____

Child's name: _____ M __ F __ Date of Birth: _____

To be completed by medical personnel

Date of exam: _____

Circle Well Child visit: 2 wk 2 mo 4 mo 6 mo 9 mo 12 mo 15 mo 18 mo 24 mo 30 mo 36 mo

Ht: _____ _____(%) **Wt:** _____ _____(%) **Hc:** _____ _____(%) **Hgb:** _____ **Hct:** _____

Date of most recent blood lead test: _____(mm/dd/yy) result _____

Medicaid policy requires lead testing at 12mo & 24mo (or once between 3-5yrs if no previous test is documented).

Vision:
Physical exam of eyes: WNL / ABN
Risk factors for vision loss: YES / NO
Parental/medical concerns: YES / NO
Further screening recommended: YES / NO

Hearing:
Otoscopic exam: WNL / ABN
Risk factors for hearing loss: YES / NO
Parental/medical concerns: YES / NO
Further screening recommended: YES / NO

	WNL	ABN
HEENT		
Skin		
Respiratory		
C-V		
M-S		
Genitals, Abdomen		
Nutrition		
Development		
Bowel Pattern		
Comments:		

Immunizations given today?	**YES**	**NO**
If yes, please list and attach immunization record.		
Immunizations catch-up plan needed? Yes ___ No ___		
Does the child have a milk allergy?	**YES**	**NO**
If yes, please list recommended substitute.		
Other allergies?	**YES**	**NO**
If yes, please list.		
Current medications?	**YES**	**NO**
If yes, please list.		

Problem/Needs	**Treatment Plan**	**Follow-up needed?**	
		Yes	**No**
		Yes	**No**

I certify that I have examined the above child on this date and that he/she is able to participate in child care activities.

Return to clinic in _____ months.

_____
Examiner's Signature

Clinic Stamp: