

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	Immunizations given today?	YES	NO
HEENT			<i>If yes, please list and <u>attach immunization record.</u></i>		
Skin					
Respiratory			Immunizations catch-up plan needed?		
C-V			Yes ___ No ___		
M-S			Does the child have a milk allergy?	YES	NO
Genitals, Abdomen			<i>If yes, please list recommended substitute.</i>		
Nutrition					
Development			Other allergies?	YES	NO
Bowel Pattern			<i>If yes, please list.</i>		
Comments:			Current medications?	YES	NO
			<i>If yes, please list.</i>		

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: