kidango

*Please DO NOT use "N/A" or leave any sections blank.

Well Baby Check/Physical Exam

Rev. February 2026

Child's Name:	**DOB:**
Date of Physical Exam:	
Circle appropriate month/year to record date exam was performed:	
2mo 4mo 6mo 9mo 12mo 15mo 18mo 24mo 30mo 3yr 4yr 5yr	
Parent/Legal Guardian Authorization: By signing below, I hereby authorize release of medical information contained in this report to Kidango child care and preschool center. x_____	
Instructions for Physician's: Please complete **ALL** sections below to ensure that the child enrolled in the Early Head Start/Head Start program has received all necessary screenings based on age.	

Assessments/Screenings	Results		
Physical Exam			
Growth Assessment	Ht.	Wt.	Head Circumference:
Hct/Hgb Blood Test Results (12 mo)			**Date of Blood Test:**
Anemia Risk Assessment	☐ No Risk Factors present		☐ Risk Factors Present
Blood Lead Test Results (12mo & 24mo)			**Date of Blood Test:**
Lead Risk Assessment	☐ No Risk Factors present		☐ Risk Factors Present
TB – Exposure Risk Assessment	☐ No Risk Factors present		☐ Risk Factors Present
TB Test Results (if applicable)	**Date Read:**		
Nutrition Assessment	☐ No Risk Factors present		☐ Risk Factors Present
Tobacco Assessment	☐ No Risk Factors present		☐ Risk Factors Present
Dental Assessment	☐ No Risk Factors present		☐ Risk Factors Present
Vision Assessment (<3 yrs)	☐ No Risk Factors present		☐ Risk Factors Present
Vision Acuity Test (3 yrs+)	☐ No Risk Factors present		☐ Risk Factors Present
Hearing Assessment (<3 yrs)	☐ No Risk Factors present		☐ Risk Factors Present
Audiometric Screening (3 yrs+)	☐ No Risk Factors present		☐ Risk Factors Present
Blood Pressure (3 yrs+)			
Developmental/Psychosocial Screening	☐ No Risk Factors present		☐ Risk Factors Present
Language/Speech	☐ No Risk Factors present		☐ Risk Factors Present
Behavioral Concerns	☐ No Risk Factors present		☐ Risk Factors Present
Autism Risk Assessment	☐ No Risk Factors present		☐ Risk Factors Present
Anticipatory Guidance	☐ Completed		
Allergies			
Asthma			
Medications Prescribed			
Special Routines/Restrictions			
Health Determination: *Is child up to date on all screenings and assessments reccommended for their age based on the American Academy of Pediatrics Bright Futures Periodicity Schedule?*	☐ Yes ☐ No If no, please explain:		
I have reviewed this information with the parent/guardian.	☐ Yes ☐ No		

Immunizations

Immunization Requirements	1st	2nd	3rd	4th	5th
Polio					
DTP					
MMR					
Hib					
Hep B					
Varicella					

Health Care Provider Information (Physician's Stamp)

Licensed Health Care Provider Signature & Title: ☐ **MD** ☐ **PA** ☐ **NP** **Date:**