Child's Name: ______________________ DOB____/____/____

PERIODIC EXAM/FOLLOW-UP RECORD

318KA (REV. 8/02)

SCREENING TESTS AND RESULTS (See Schedule)

SCREENING TESTS	DATE DONE	RESULTS
Hematocrit or Hemoglobin		Hct. % / Hb gms %
Newborn Screening or Hemoglobin Electrophoresis		
Lead Risk Assessment		
Lead Screening (Venous preferred)		
Tuberculin Screening (PPD Mantoux)*		
Vision Screening		
Hearing Screening		
Urinalysis (Optional)		
OTHER TESTS (*Specify*)		

* See recommended schedule: Not required for all children.

DENTAL ASSESSMENT Date: ____/____/____

1. **Examiner** ☐ MD ☐ DDS ☐ Dental Hygienist
   ☐ Other Health Care Professional (*Specify*)__________
2. **Does the child sleep with a bottle?** ☐ Yes ☐ No
3. **Findings** **A. No Visible Problems** .... ☐
   (*Clean mouth, no visible cavities, healthy gums*)
   B. Some Problems Detected .... ☐
   (*Cavities, inflamed gums, open bite, malocclusion*)
   C Severe Problems .... ☐
   (*Baby bottle tooth decay; extensive cavities; abscesses*)
   D. Other (*Specify*): .... ☐
   Referral Suggested if B, C or D is checked
4. Has the child been referred to Dentist? ☐ Yes ☐ No

NUTRITIONAL UPDATE

Up to age 1 year: Is the child on?
- Formula? ☐ No ☐ Yes
- Breast milk? ☐ No ☐ Yes
- Solid foods? ☐ No ☐ Yes

1 year and above:
- Is child bottle fed? ☐ No ☐ Yes
- Type of diet?__________

Unusual dietary habits? ☐ No ☐ Yes, specify __________

Dietary restrictions? ☐ No ☐ Yes, specify__________

IMMUNIZATION HISTORY

	DATE IMMUNIZATION GIVEN				
	1st	2nd	3rd	4th	5th
DTP					
DT					
DTaP					
Hib					
OPV/IPV					
Hep B					
MMR					
Varicella					
Pneumococcal					

DIAGNOSES/PROBLEMS/CLINICAL IMPRESSIONS

(Include all chronic conditions or conditions/findings needing follow-up)

1. __________
2. __________
3. __________
4. __________
5. __________

PLAN (Therapies, Referrals, F/U)

1. Next Appointment Date ____/____/____
2. Follow-up Needed ☐ Yes ☐ No
   (Specify referral and date)
3. __________
4. __________
5. __________

RECOMMENDATIONS

1. Approve participation in early childhood program/day care? Yes ☐ No ☐
2. Special recommendations for child? Specify treatments provided, or recommended evaluations. Does child require special education or early intervention? __________

Name/Address Stamp, if available:

Signature __________ Date of Exam. __________

Name (PLEASE PRINT) __________ Degree: __________

License No. __________ Telephone No. __________

Address __________