



Immunization:	Record date of each dose received (mm/dd/yy)					*Required	**Recommended			
	1st	2nd	3rd	4th	5th		1st	2nd	3rd	4th
DPT (Diphtheria, pertussis, tetanus)*						MMR (Measles, Mumps, Rubella) *				
Td/DT *							HBV (Hepatitis B) **			
OPV or IPV (Polio) *						TB (Skin Test) *	Date	Result		

**Immunization:** Record date of each dose received (mm/dd/yy) \*Required \*\*Recommended  
**PHYSICAL EXAMINATION:** To be completed by health care provider approved to perform health assessments.

Height _____	Weight _____	Hgb or Hct _____
Pulse _____	Blood Pressure _____	Lead _____
Urinalysis _____	Sickle Cell _____	Other _____
Tuberculosis _____	Head Circumference _____	

Code Each Item as Follows: 0 = No significant findings 1 = Significant findings	Code	Description of Findings
General Appearance		
Integument		
Head - Neck		
EENT		
Oral - Dental		
Thorax		
Breasts		
Cardiovascular		
Abdomen		
Musculoskeletal		
Genitourinary		
Neurological		

**SCREENING**

1. Nutritional Evaluation (all ages - each screen) (T if applicable) Nutrition/WIC Questionnaires available from (785) 296-0092.  
 Enrolled in WIC     Receiving Vitamin Supplement with iron     Without iron     Fluoride Supplement
- Food intake review. Results:  
milk/milk products (breast-fed/type of formula) \_\_\_\_\_  
fruit/vegetables \_\_\_\_\_  
meat, beans, eggs \_\_\_\_\_  
breads, cereals \_\_\_\_\_
- Type of screen \_\_\_\_\_
2. Development \_\_\_\_\_ Results \_\_\_\_\_
3. Speech \_\_\_\_\_ Results \_\_\_\_\_
4. Hearing \_\_\_\_\_ Results \_\_\_\_\_ Date of last screen \_\_\_\_\_
5. Vision \_\_\_\_\_ Results \_\_\_\_\_ Date of last screen \_\_\_\_\_

Significant Assessment Findings:

Anticipatory Guidance: (circle those discussed)

- |                    |               |                |
|--------------------|---------------|----------------|
| 1. Safety/poisons  | 8. Lifestyle  | 9. Development |
| 2. Nutrition       | 10. Behavior  |                |
| 3. Parenting       | 11. Sexuality |                |
| 4. Family Planning | 12. Dental    |                |
| 5. Discipline      | 13. Other     |                |
| 6. Immunizations   |               |                |
| 7. Hygiene         |               |                |
- Comments:

Recommendations: (include referrals)

Follow Up:

Additional Information may be attached

Signature of Licensed Physician or Nurse approved to perform health assessments. \_\_\_\_\_ Date \_\_\_\_\_