BUSSEY CENTER FOR EARLY CHILDHOOD EDUCATION
24501 Fredrick Street * Southfield, MI 48033
Phone (248) 746-7350 * Fax (248) 746-7354

HEALTH SCREENING

Child's Name: _____ Birthdate: _____

Address: _____

Parent/Guardian Name: _____ Phone #: _____

Immunization History (or provide printout)

	Dose 1	Dose 2	Dose 3	Dose 4	Dose 5
DTaP					
IPV					
MMR					
Hib					
Hep B					
PCV 7					
VARICELLA					

TB TEST Yes ___ No ___ Date given: _____ Date read: _____ Results: _____

EXAMINER: all areas below must be completely filled out. Federal government required screenings for Head Start child to be enrolled. NO PENDING RESULTS ON THIS FORM PLEASE.

HEIGHT: _____ WEIGHT_____ BMI:_____
B/P: _____NUTRITION STATUS:_____
URINALYSIS: Normal _____ Abnormal_____
HGB/HCT: (most recent results):_____Date:_____
SICKLE CELL: Trait _____ Disease _____
LEAD LEVEL: (most recent results):_____Date:_____
VISION: Pass ____ Fail ____ To Young to Screen ___
Vision Screening Date: _____
HEARING: Pass ____ Fail ____ To Young to Screen ___
Hearing Screening Date: _____

PLEASE ANSWER THE FOLLOWING QUESTIONS REGARDING THIS CHILD:

ALLERGIES: YES ___NO ___(food, medicine, environment):
List: _____
Medication_____
ASTHMA: YES ___NO ___
Medication_____
Any concerns regarding this child's weight/height?_____
_____
Any concerns regarding this child's development?_____
_____
Any concerns regarding this child's behavior?_____
_____

PHYSICIAN (Please check below and mark any findings deviating from normal):

Normal	Yes	No	Describe if abnormal results	Normal	Yes	No	Describe if abnormal results
Appearance				Glands			
Posture/Gait				Heart			
Speech				Lungs			
Head				Bones/Joints			
Skin				Muscles			
Eyes/Vision				Abdomen			
Ears/Hearing				Genitalia			
Nose/Mouth				Other			

Should activities be restricted? No _____ Yes* _____ Explain* _____
Doctor/Examiners' Name: (printed)_____Phone: _____
Address: _____
Doctor/Examiner's Signature: _____ Date: _____

Please specify Exam Date: _____

Official Office Stamp Please: