



NEW Health Events: Preschool

Child's Name: _____		DOB: _____	
Event Name	Date	Status (Pass/Fail)	Results
Blood Lead			
Blood Pressure (3 and 4 year-olds)			
Dental Exam (Check one: <input type="checkbox"/> Medi-CAL <input type="checkbox"/> Head Start <input type="checkbox"/> Private <input type="checkbox"/> None)			
Growth Assessment		NA	Ht: Wt:
Health Assessments (Health History, Nutrition History, Tobacco Assessment and Dental Information)		Completed	
Hearing			
Hgb/Hct (Check one: <input type="checkbox"/> Blood test <input type="checkbox"/> Screening)			
Lead Risk Assessment			
Preventive Dental		Completed	
Well Child Check/Physical Exam		Completed	
TB Risk Assessment			
Vision			
Medical Health Status Determination:	Dental Health Status Determination:		
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