

NEW Health Events: EHS

REMEMBER TO SUBMIT COPIES OF ALL WELL CHILD CHECKS WITH REQUIRED ITEMS HIGHLIGHTED

Child's Name:		DOB:	
Event Name	Date	Status (Pass/Fail)	Results
Dental Exam			N/A
Health Assessments <small>(Health History, Nutrition History, Tobacco Assessment & Dental Information)</small>		Completed	N/A
Hgb/Hct 12 mos.			
Lead (Blood Test): <input type="checkbox"/> 12 mos. <input type="checkbox"/> 2 – 5 yrs			
Lead Risk Assessment			N/A
TB: <input type="checkbox"/> Test or <input type="checkbox"/> Risk Assessment			
Growth Assessment		N/A	Ht:
			Wt:
			HC:
Hearing			N/A
Vision			N/A
Dental Health Status Determination		Completed	N/A
Medical Health Status Determination		Completed	N/A
Child's Name:		DOB:	
Event Name	Date	Status (Pass/Fail)	Results
Dental Exam			N/A
Health Assessments <small>(Health History, Nutrition History, Tobacco Assessment & Dental Information)</small>		Completed	N/A
Hgb/Hct 12 mos.			
Lead (Blood Test): <input type="checkbox"/> 12 mos. <input type="checkbox"/> 2 – 5 yrs			
Lead Risk Assessment			N/A
TB: <input type="checkbox"/> Test or <input type="checkbox"/> Risk Assessment			
Growth Assessment		N/A	Ht:
			Wt:
			HC:
Hearing			N/A
Vision			N/A
Dental Health Status Determination		Completed	N/A
Medical Health Status Determination		Completed	N/A