

PHYSICIAN'S EARLY CHILDHOOD SCREENING SUMMARY

CHILD'S NAME _____ **SCREENING DATE:** ____Month ____Day ____Year
BIRTHDATE: ____Month ____Day ____Year **AGE:** ____Years ____Months

OK
Rescreen
Refer _____

Screener's Initials _____

COMPONENTS:

FINDINGS:

Physical Assessment*

Last Well Child Visit
____/____/____

Dental Inspection

Last Dental Visit
____/____/____

Laboratory Tests*

Lead _____

HEALTH HISTORY/CURRENT STATUS:*

Past Health History _____

Present Health Status _____

Health Behaviors/Practices _____

NUTRITION ASSESSMENT: _____

GROWTH:* Height _____ (____% tile) Weight _____ (____% tile)

IMMUNIZATION REVIEW:

VISION:

Observation _____

Acuity
Rescreen

R 10/_____
R 10/_____

L 10/_____
L 10/_____

Muscle Balance

HEARING:

Screen
Rescreen

R _____
R _____

L _____
L _____

DEVELOPMENT: (general findings, not scores)

Tool: _____

Cognitive _____

Fine Motor _____

Gross Motor _____

Speech & Language _____

Social – Emotional _____

Parent report of Development _____

FAMILY FACTORS:

Home, Child Care_____

Access to Health Care_____

Family Members_____

Resources & Needs_____

COMMENTS:**EARLY EDUCATION EXPERIENCES:****SUMMARY:** (The child's strengths and needs may be recorded here)**PRIORITIES****REFERRALS & RESOURCES****TIMELINE****DENTAL:
IMMUNIZATIONS:**Refer for Initial Visit
Given On Site_____

Referred_____

*Signature of Parent*_____
*Signature of Summary Interviewer/Position*_____
*Telephone Number***Copies Distributed To:**

___Parent

___Health Care Provider (with consent)

___School District Pupil Health Record (with consent)

Follow-Up: _____

Return all forms to: Edgewood School
Attn: Screening Dept.
5304 Westwood Dr. SE
Prior Lake, MN 55372