Picayune School District Head Start / Early Head Start
Check-up Form

Child's Name: _____ DOB: _____
Date of Service: _____ Allergies? _____
Doctor/Nurse Practitioner: _____

Age Appropriate Check-up: (Please choose One)

2 month 4 Month 6 Month 9 Month 12 Month 15 Month

18 Month 2 Year 30 Month 3 Year 4 Year 5 Year

Needed Documentation:
Growth Assessment: Wt: _____ Ht: ____ Hc: ____
BP: (done at 3, 4 & 5 years of age) ____/____

Developmental Assessment: WNL: ____ Not WNL: ____
Comments/Concerns:

_____

_____

Speech concerns? Yes: ____ No: ____
Vision: WNL ____ Not WNL ____
Hearing: WNL ____ Not WNL ____
Dental Screening: WNL ____ Not WNL ____

HGB Results
12 months - Blood _____
4 Years – Blood _____

Lead Level Results:
12 months - Blood _____
2 Years – Blood _____
4 Years – Blood _____

Comments/Concerns/new orders:

_____

_____

_____
Signature of Physician/Nurse Practitioner