Next Door Health Office
2545 North 29th St
Milwaukee, WI 53210
414-562-2929 ext. 2310
414-918-2743 fax

Infant/Toddler Physical Exam

NAME:_____DOB:_____ M___F___ Exam date:_____

ALLERGIES:_____

Medications: _____

Food Allergies/Dietary Restrictions:_____

Circle Well Child Visit: 2wk 2mo 4mo 6mo 9mo 12mo 15mo 18mo 24mo 30mo 36 mo

Ht: _____" Wt: _____# OFC_____ Vision screening : □ pass □ fail Hearing screening : □ pass □ fail

Hgb:_____ (Date) Lead:_____ Date (if different from visit):_____
(Medicaid Policy requires lead testing at around 12 mo, 18, and 24 mo, and annually at ages 3, 4, and 5yrs if in City of Milwaukee)

Please indicate any significant past medical history (surgery, prematurity, delays, therapies):

Exam Findings:	nl	See Note
Eyes/Vision (red reflex)		
ENT/Mouth		
Teeth/Oral Health		
Cardiovascular		
Respiratory		
Gastrointestinal		
Genitourinary		
Musculoskeletal		
Skin		
Neurological		
Development		

□ Fluoride Varnish Applied

Medical Condition/Problem/Need:	Treatment Plan:	Follow-up Needed by Head Start Staff?
		□ no □ yes, please indicate how we can help

Physician/Clinic Name, Address, and Phone (may stamp):	Immunizations: Please attach copy of WIR or attach a copy of the records:

I certify that I have examined the above child on this date and that he/she is able to participate in Early Head Start activities.

Signature:_____ Date of Exam: _____ Return to clinic in _____ months

Next Door Staff: _____