



Mid-West New Mexico Community Action Program

549 Don Pasqual Rd. Los Lunas, NM 87031

Phone (505) 866-0466 Fax (505) 865-1506

May 1, 2026

Dear Families,

Welcome to Mid-West New Mexico Community Action Program's Head Start and Early Head Start!

It is truly an honor to welcome you and your child into our program. At MWNM CAP, we are deeply committed to providing high-quality early childhood education and comprehensive services to children and families across Cibola, McKinley, Socorro, and Valencia Counties. For over 50 years, our program has supported families by creating strong educational foundations and meaningful opportunities for growth.

We believe that every child deserves a safe, nurturing, and engaging environment where they can learn, explore, and thrive. Just as importantly, we recognize that families are a child's first and most important teachers. Your partnership is essential, and we value the role you play in your child's development. At MWNM CAP, family engagement is not just encouraged, it is at the heart of everything we do.

As you begin this journey with us, we encourage you to complete your child's application as soon as possible. Due to limited enrollment availability, submitting a complete application with all required documentation (proof of income, birth certificate, immunization records, etc.) will help ensure timely processing and eligibility determination.

To support your child's success and well-being, it is also important that each child receives a complete physical examination before the start of the program year. This allows us to better understand and support your child's individual health needs, including any allergies, medical conditions, or prescribed medications. Maintaining up-to-date health and immunization records is required in accordance with federal, state, and local regulations and ensures your child can fully participate throughout the year.

Our team is here to support you every step of the way. If you have questions about the application process, required documents, or scheduling your child's physical, please do not hesitate to contact your local center. We are here to help.

We are excited to partner with you and look forward to building a strong, supportive relationship with your family. Thank you for trusting us with your child's early learning experience.

Welcome to the MWNM CAP family. We are glad you are here.

Warm regards,

An Jeanette Maria Paredes, M.A.
Head Start / Early Head Start Director
Mid-West New Mexico Community Action Program

When submitting your application, please bring the following documents with you:

- **Proof of Income (All Household Members) - This may include one or more of the following:**
 - 2024 Income Tax Forms
 - W-2 Form(s)
 - Pay Stubs/Pay Envelopes -most current
 - Written statement from employer
 - Documentation showing current status as recipients of public assistance (TANF, SNAP or SSI)
 - Documentation showing foster care status for the applying child
- **Original Certificate of Birth (or foreign equivalent) or a hospital certificate of birth until an official certificate of birth can be obtained**
- **Child's Health Insurance or Medicaid Card**
- **Child's Immunization Records**

Please provide the following documents at time of application (if not currently available, please provide "Notice of Appointment" or speak to our Parent, Family and Community Engagement Department for assistance):

- Child's Physical (HS within the last 12 months, EHS within the last 3 months)
- Child's Dental Screening(s)/Exam(s) (within the last 12 months) and if applicable:
- Certificate of Indian Blood

If your child has not had a physical within the last 12 months, please schedule one as soon as possible. It is a requirement that all Head Start children have a physical within the last 12 months. If you have any questions or problems, please contact your local Head Start and they will be happy to assist you.

EMERGENCY CONTACT/PICK-UP FORM

(Anyone other than Parent/Guardian must be 18 or older to sign-out child)

Applicant/Child's Name _____

Parent /Guardian 1

First Name	Last Name
Address:	
Home Phone #:	Phone 2/Cell #:
Gender: Male ___ female. ___	Relationship to Child: Pick-Up Child

Parent /Guardian 2

First Name	Last Name
Address:	
Home Phone #:	Phone 2/Cell #:
Gender: Male ___ female. ___	Relationship to Child: Pick-Up Child

Emergency Contacts in Local Area Who May Also Pick Up Child

Contact 1 - First Name	Contact 1 - Last Name
Home Phone #:	Phone 2/Cell #:
Gender: Male ___ female. ___	Relationship to Child:

Contact 2 - First Name	Contact 2 - Last Name
Home Phone #:	Phone 2/Cell #:
Gender: Male ___ female. ___	Relationship to Child:

Contact 3 - First Name	Contact 3 - Last Name
Home Phone #:	Phone 2/Cell #:
Gender: Male ___ female. ___	Relationship to Child:

Additional Individuals Who May Pick-up My Child

NAME	PHONE #	RELATIONSHIP

Parent/Guardian Signature

Date

**CONSENT FOR CHILD'S EMERGENCY MEDICAL/DENTAL TREATMENT
AND TRANSPORTATION PERMISSION FORM
(By Parent or Legal Guardian)**

I, _____, hereby give my consent for emergency medical and/or dental treatment of the child listed below by any licensed physician or dentist while under the care of Mid West NM CAP Head Start and for emergency transport of the child to and from the source of emergency treatment. My child will be transported by an ambulance or other such vehicle when necessary.

This emergency care may include examinations and any tests which in the opinion of the physician or dentist are deemed necessary or advisable.

This does not include the right to perform surgical operations without my further consent, except in the case of an emergency and when an effort has been made to locate me or if I am found to be unavailable.

I understand that emergency treatment will not be given without parental consent, except in a life-threatening situation. Since consent must be given at the time of the incident, I understand that I must leave numbers where I, my spouse or a responsible adult designated by me, may be reached.

I understand the procedure to be followed and hereby authorize the Center to follow this procedure in the event of an emergency.

This consent is valid for one year after the date signed.

Child's Name: _____ Date of Birth: _____

Allergies/Medical Condition(s): _____

Physician: _____ Dentist: _____

Hospital: _____ Insurance: _____

Staff Use			
DTAP :			
Assigned Bus Stop:			
Re-Assigned Bus Stop:		Effective Date:	
Re-Assigned Bus Stop:		Effective Date:	

CONSENTS
 Consents/Permissions/Verifications Form
 PROGRAM YEAR 2026-2027

Eligible Child: _____

CONSENT AND APPROVALS

I give permission to Mid West NMCAP Head Start Program to do the following screenings.

Screenings:

<input type="checkbox"/> Vision	<input type="checkbox"/> Hearing	<input type="checkbox"/> Developmental Screenings and Assessments
<input type="checkbox"/> Height and Weight	<input type="checkbox"/> Behavior Health & Wellness Observation	

Permissions:

Transportation of Child

Use of child's photograph/pictures on Social Media and for Recruitment/Advertisement

Use of child's photograph/pictures for classroom use only.

Parent/Guardian Signature: _____		Signature Date: _____	_____ / _____ / _____ Month Day Year
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DECLINATIONS

I do not give permission for the following screenings. I acknowledge and remove all responsibility from the Mid West NMCAP Head Start Program for denial of services.

Screenings:

<input type="checkbox"/> Vision	<input type="checkbox"/> Hearing	<input type="checkbox"/> Developmental Screenings and Assessments
<input type="checkbox"/> Height and Weight	<input type="checkbox"/> Behavior Health & Wellness Observation	<input type="checkbox"/> Medical Release

Permissions:

Transportation of Child

Use of child's photograph/pictures on Social Media and for Recruitment/Advertisement

Use of child's photograph/pictures for classroom use only.

Parent/Guardian Signature: _____		Signature Date: _____	_____ / _____ / _____ Month Day Year
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RELEASE OF INFORMATION FORM

Name of Child: _____ Date of Birth: __/__/____

Address: _____

City: _____ State: _____ Zip: _____

I, _____ hereby authorize _____
print name of Parent/Guardian* (person)

of _____
(name of doctor's office, school, other)

to obtain the following information about the above-named child:

(Check all that apply)

all medical records currently on file at _____ .
Medical Provider

only following medical records _____

currently on file at _____ .

all dental records currently on file at _____

In addition, I authorize

(1) _____ to release information concerning
the above named child to: _____

(2) _____ to release information concerning
the above named child to: _____

This authorization will automatically terminate on _____ unless previously revoked or
extended by me, the undersigned.

Signature of Parent/Guardian* date

____ I hereby revoke this authorization _____
Signature of Parent/Guardian* date

____ I hereby extend this authorization for ____ months _____
Signature of Parent/Guardian* date

*If the patient is over __ years of age, he or she may sign in place of parent/guardian.

Mid-West New Mexico Community Action Program

Child Health History Questionnaire

Child's Name:	DOB:	Sex: M F
Parent/Guardian Name:		Date:
PREGNANCY/BIRTH HISTORY	Y N	EXPLAIN "YES" ANSWERS
1. Did mother have any health problems during this pregnancy or delivery?		
2. Did mother visit physician fewer than two times during pregnancy?		
3. Was child born outside of a hospital?		
4. Was child born more than 3 weeks early or late?		
5. What was child's birth weight?		lbs. oz.
6. Was anything wrong with the child at birth?		
7. Was anything wrong with the child in the nursery?		
8. Did child or mother stay in hospital for medical reasons?		
9. Is mother pregnant now?		
HOSPITALZATIONS AND ILLNESSES	Y N	EXPLAIN "YES" ANSWERS
10. Has child ever been hospitalized or operated on?		
11. Has child ever had a serious accident?		
12. Has child ever had a serious illness?		
HEALTH PROBLEMS	Y N	EXPLAIN (Use additional sheets if needed)
13. Does child have frequent: ___ sore throat; ___ cough; ___ urinary infections or trouble urinating; ___ stomach pain, ___ vomiting or diarrhea		
14. Does the child have difficulty seeing? (squints, cross eyes, look closely at books)		
15. Is child wearing (or suppose to wear) glasses?		If yes, was last checkup more than a year?
16. Does the child have problem with ears/hearing?		
17. Have you ever noticed child scratching their behind while asleep?		
18. Has child ever had a convulsion or seizure? Is the child taking medication for seizures?		When did it last happen? What medicine?
19. Is child taking any other medicine now?		
20. Is child now being treated by a physician or a dentist?		Physician Name: Dentist Name:
21. Has child had: ___ boils; ___ chickenpox; ___ eczema; ___ German measles; ___ measles; ___ mumps; ___ scarlet fever; ___ whooping cough		
22. Has child had: ___ hives; ___ polio		
23. Has child had: ___ asthma; ___ bleeding tendencies; ___ diabetes; ___ epilepsy; ___ heart/blood vessel disease; ___ liver disease; ___ kidney disease; ___ rheumatic fever; ___ sickle cell disease?		
24. Does child have any allergies?		
25. Does the child have any condition that will get in the way of the child's everyday activities? Did a doctor or other health professional tell you the child had this problem?		Describe how? When?

**West New Mexico Community Action Program
Early Head Start Program**

Diet Restriction/Food Allergy Form

Child's Name: _____ DOB _____

Diet Restriction:

- None
- Cultural Preference/Religious Preference
- Allergy/Medical Restriction (*physician signature is **required** by the entry date of the child*)

****Your child's physician must complete the portion below prior to the first date of entry****

If your child requires a special diet, please have the physician include a detailed description of what food(s) your child is allergic to, and describe any reactions or adverse consequence that may occur if your child is exposed to that food(s).

List specific food to be omitted and suggested substitutions:

Omissions

Substitutions

Parent/Guardian's Signature _____ Date _____

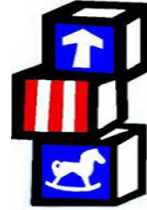
Physician Signature _____ Date _____

Your child's special needs information will be posted in places that are accessible to staff in order to keep your child safe, but out of access to others.

If your child is on a Health Plan, it will follow the child while he/she is enrolled in the Program. The Health Plan may be withdrawn **ONLY** with a physician statement explaining that the condition no longer exists or no longer needs monitoring.



**Mid-West New Mexico Community Action Program
Early Head Start Program**



**Early Head Start Child Health Record
Nutrition**

Child's Name: _____ Date of Birth: _____ Sex: M F
Parent/Guardian: _____ Relationship: _____
Name of Interviewer: _____ Title: _____

The following questions will help us understand your child's nutrition needs better:

1. Are there any foods that child cannot eat due to religious, cultural, or medical reasons? No Yes
If "Yes," what foods are these? _____
2. Does your child take a vitamin/supplement? No Yes If "Yes," what kind?

Do they contain Iron? No Yes Do they contain Fluoride? No Yes
3. Does your child have a food allergy? No Yes If "Yes," please explain:

4. Is your child on a special diet? No Yes If "Yes," what kind?

Was it prescribed by a physician? No Yes
5. Does your child use a bottle? No Yes
6. Does your child drink milk? Breast Milk Formula Cow's Milk Other: _____
What kind (formula or Cow's milk)? _____ How much? _____ How often? _____
7. Does your child eat solid foods? No Yes If "Yes," what type of food (i.e. baby food, table food)?

8. Does your child have the following issues? Vomiting Constipation Diarrhea Difficulty Chewing
 Difficulty Swallowing Pain while eating None
9. Does your child ever eat non-food items such as, clay, dirt, paper? No Yes If "Yes," what?

10. Do you have concerns about what your child eats? No Yes. If "Yes," what are your concerns?

11. Does your family have at least one meal together? No Yes
Is the TV on during meal time? No Yes
Do the children and adults eat the same meal? No Yes
12. Does your child feed themselves? No Yes



**Mid-West New Mexico Community Action Program
Early Head Start Program**



13. How often does your family have take-out food?

14. Does your child use the following:

Utensils (fork, spoon, knife)? No Yes

Open cup? No Yes

Sippy cup? No Yes

15. What are some of your child's favorite foods? _____

16. What are some foods that your child dislikes? _____

17. How much does your child eat from each of these food groups in a typical day?

Milk, cheese, yogurt _____

Fruits (Not Juice) _____

Vegetables _____

Meat, poultry, fish, eggs, dried beans/peas, peanut butter _____

100% Fruit Juice _____

Kool-Aid, soda, sports drinks, fruit flavored drinks, tea, coffee _____

Salty snacks, chips, etc. _____

Cookies, candy, cakes, ice cream, sweet snacks _____

Bread, cereal, crackers, tortillas, rice, muffins, rolls _____

Parent/Guardian Signature: _____ Date: _____

Mid-West New Mexico Community Action Program

Parent Transition Questionnaire

Child's Name:	DOB:	Sex: M F
Parent/Guardian Name:	Relationship to Child:	
1. Can you tell us one or two things your child is interested in or does especially well?		
2. Does your child take a nap? ___Yes ___No If yes, how long?		
3. Does your child sleep less than 8 hours a day or have trouble sleeping? ___ Yes ___ No Explain if yes:		
4. How does your child tell you when they need to use the restroom?		
5. Does your child need help going to the restroom? ___Yes ___No Explain:		
6. Does your child often wet their pants? ___Yes ___No Explain:		
7. How does your child act with adults they do not know?		
8. How does your child act when playing with a group of other children?		

Mid-West New Mexico Community Action Program

Parent Transition Questionnaire

9. Does your child worry a lot or is he/she afraid of anything? ___ Yes ___ No Explain:
10. Has your child ever been identified as having a developmental delay? ___ Yes ___ No If yes, please explain:
11. Does your child have any difficulties saying what they want to do? ___ Yes ___ No Explain:
12. Do you have any trouble understanding your child? ___ Yes ___ No Explain:
13. Does your child often get cranky or cry at other times, when you can't figure out why? ___ Yes ___ No Explain:
14. What do you do to comfort your child when they cry or are scared?
15. Please describe any major changes in your child's life in the last six months:
16. Are you or your family having any problems that might affect the child at school? ___ Yes ___ No Explain:
17. Does your child currently wear diapers or pull-ups? ___ Yes ___ No If yes, what brand? _____ Size? _____
18. Name of school your child will transition to after Head Start.
19. Is there any additional information that you would like us to know about your child?

Child Lead Exposure Questionnaire

Child's Name: _____ DOB: _____ Center: _____

Please answer these questions with: **Yes, No, or Don't Know**. The answers will help you and your health care provider decide if your child needs a blood test for lead.

1.	Is your child enrolled in or eligible for Medicaid? <i>Children enrolled in Medicaid are <u>required by law to be tested for lead at 12 months and again at 24 months of age</u>, and between the ages of 36 months and 72 months of age, if not tested at 12 and 24 months of age.</i>	Yes	No	Don't know
2.	Is your child enrolled in any public assistance programs such as WIC or TANF?	Yes	No	Don't know
3.	Does your child live in, or regularly visit (for daycare or babysitting), a house built before 1950? <i>Older houses may have lead-based paint, which breaks down into dust that can be swallowed or inhaled by your child.</i>	Yes	No	Don't know
4.	Does your child live in or regularly visit a house that has recently been remodeled? <i>Remodeling in an older house, or even one built as late as 1978, can create dust that contains lead, if lead-based paint is present.</i>	Yes	No	Don't know
5.	Does any other child of yours or a child of a relative or friend have an elevated blood lead level?	Yes	No	Don't know
6.	Does your child live with or regularly visit an adult whose work or hobby uses lead?	Yes	No	Don't know
7.	Do you (or any family members, or a curandera or sobador) give your child orange, red, or yellow powder such as Greta or Azarcon, or use "Navajo" clay for stomach ache, nausea, and diarrhea?	Yes	No	Don't know
8.	Do you use Kohl, Alkohol, or Surma on your child's skin? Or use traditional Middle Eastern, Oriental, and Ayurvedic preparations?	Yes	No	Don't know
9.	Does your home have imported plastic/vinyl mini-blinds? <i>Some imported plastic mini-blinds made before 1996 have lead in them.</i>	Yes	No	Don't know
10.	Does your child eat, put things in his/her mouth, or chew on things that aren't food? <i>Dirt, wood (especially window sills), paint chips, jewelry, shell casings, fishing sinkers, lead shot, shoes, or socks can have lead or lead dust on/in them.</i>	Yes	No	Don't know
11.	Do you use imported pottery for cooking, storing, or serving food? <i>Some Mexican, Chinese, and Italian potteries have lead in the glaze, which can get into the food.</i>	Yes	No	Don't know
12.	Does your child live or play near a junkyard, dump, mine, smelter, busy street, or highway? <i>These places can have lead dust in the air or in the dirt. Even if the smelter or mine is closed, lead can still be in the dirt.</i>	Yes	No	Don't know
13.	Does your child eat tamarind/chile candy or salt/lemon/chile seasonings or chapulines that are made in Mexico? <i>Some of these products may contain lead.</i>	Yes	No	Don't know

Parent Signature: _____

Date: _____

Staff Signature: _____

Date: _____

NM Childhood Lead Poisoning Prevention Program
 Environmental Health Epidemiology Bureau
 505-827-0006 • DOH-eheb@state.nm.us



Rev 4/2025

MWNMCAP Hematocrit/Hemoglobin Risk Assessment Questionnaire

Child's Name: _____ DOB: _____ Center: _____ Class: _____

Iron deficiency anemia is surprisingly common, yet it often goes undiagnosed and untreated. When diagnosed, there are treatments available to help correct and manage iron deficiency anemia. If you don't get treatment, however, you may end up feeling worse and worse. By answering this simple questionnaire, you can help us determine if your child needs a Hemoglobin/Hematocrit test. Just answer as many of the questions as you can, and be sure to share the results with your physician.

1. Does your child feel tired or fatigued?

Always Often Sometimes Never

2. Does he/she feel weak?

Always Often Sometimes Never

3. Does your child's skin look pale?

Always Often Sometimes Never

4. Does your child get short of breath?

Always Often Sometimes Never

5. Does your child get dizzy?

Always Often Sometimes Never

6. Is it difficult for your child to concentrate?

Always Often Sometimes Never

7. Has your child experienced a rapid heartbeat?

Always Often Sometimes Never

8. Does your child complain of numbness or coldness in their hands or feet?

Always Often Sometimes Never

9. Is your child irritable?

Always Often Sometimes Never

10. Does your child feel sad or depressed?

Always Often Sometimes Never

11. Is child's hemoglobin count below 11 g/dL (**grams per deciliter**) of blood?

Yes No I Don't Know

12. Have you ever been told that your child was anemic?

Yes No

Parent Signature: _____

Date: _____

Child Does Does not need a follow-up Hematocrit/Hemoglobin or Lead test.

(If follow-up is needed, check the box and circle test needed)

Staff Signature: _____

Date: _____

MID-WEST NM COMMUNITY ACTION PROGRAM
FAMILY HANDBOOK

(Parent/Guardian -PRINT NAME)

(Child's Name -PRINT)

I hereby acknowledge that I have received orientation and have been provided with a copy of the Mid-West NM CAP–Early Childhood Development Center Family Handbook.

I further acknowledge that I have read and understand its contents.

(Parent/Guardian Signature)

(Date)

(County)

ACKNOWLEDGMENT FORM
Parent/Guardian Use



Head Start Oral Health Form—Children

Patient Information

Child's name _____ Date of birth _____ Parent's/guardian's name _____ Phone number _____
Address _____ City _____ State _____ Zip code _____
This practice is the child's dental home: Yes No

Current Oral Health Status

Does the child have any teeth with untreated decay? Yes (decay) No (decay free)
Does the child have any teeth that have previously been treated for decay, including fillings, crowns,
or extractions? Yes No
Are there treatment needs? Yes, urgent Yes, not urgent No treatment needs

Oral Health Care Services Delivered During Visit

Diagnostic/Preventive Services	Counseling/Anticipatory Guidance	Restorative/Emergency Care
Examination: Yes No	Yes No	Fillings: Yes No
X-rays: Yes No		Crowns: Yes No
Risk assessment: Yes No	Referral to Specialty Care	Extractions: Yes No
Cleaning: Yes No	Yes No	Emergency care: Yes No
Fluoride varnish: Yes No	_____	Other: _____
Dental sealants: Yes No	<i>(Please specify specialist)</i>	<i>(Please specify)</i>

Future Oral Health Care Services

All treatment completed: Yes No Next recall date: _____ / _____ (month/year)
More appointments needed for treatment? Yes No
If yes: Approximate number of appointments needed: _____ Next appointment: Date: _____ Time: _____

Additional Information for Parents, Head Start Staff, and Medical Providers

Oral Health Provider's Contact Information and Signature

Provider name *(please print)* _____ Phone number _____ Fax number _____
Practice name _____ Address _____
Provider signature _____ Date of service _____

Mid-West New Mexico Community Action Program

Child Health Record-Screenings, Physical Examination/Assessments

Child's Name:					Center/Class:				
Parent/Guardian Name:					Child's Birth Date:				
Provider Information									
Provider Name:					Phone #:				
Address:									
Section 1-Physical Assessment					Section 2-Child Health Status				
	Normal	Abnormal	Refer	Not Examined					
General Appearance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Child is up-to-date on a schedule of age appropriate preventative and primary care? Yes <input type="checkbox"/> No <input type="checkbox"/>				
Posture, Gait	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					
Head	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					
Skin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					
Eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					
Ears (external canal)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Child needs to establish the following services: Well Child Care Yes <input type="checkbox"/> No <input type="checkbox"/> Immunizations Update Yes <input type="checkbox"/> No <input type="checkbox"/> Routine Dental Care Yes <input type="checkbox"/> No <input type="checkbox"/> Mental Health Yes <input type="checkbox"/> No <input type="checkbox"/>				
Nose, Mouth, Pharynx	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					
Teeth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					
Heart	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					
Lungs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					
Abdomen (hernia)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Child has acute and chronic conditions and : Yes <input type="checkbox"/> No <input type="checkbox"/> is receiving adequate ongoing care Yes <input type="checkbox"/> No <input type="checkbox"/> needs to establish services Yes <input type="checkbox"/> No <input type="checkbox"/> needs to update or re-establish services Yes <input type="checkbox"/> No <input type="checkbox"/>				
Bones, Joints, Muscles	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					
Neurological									
Gross Motor	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					
Fine Motor	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					
Glands					Child has suspect or significant concerns. Yes <input type="checkbox"/> No <input type="checkbox"/> Explain:				
Lymphatic/Thyroid	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					
Muscular Condition	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Child's status was determined by: Parent Report Yes <input type="checkbox"/> No <input type="checkbox"/> Medical History Yes <input type="checkbox"/> No <input type="checkbox"/> Today's Exam Yes <input type="checkbox"/> No <input type="checkbox"/>				
Abnormal Conditions	_____								
Asthma/Allergies	_____								
Current Medications	_____								
Section 3-Standard Tests & Measurements									
			Normal	Abnormal			Normal	Abnormal	
Blood Pressure	_____ / _____		<input type="checkbox"/>	<input type="checkbox"/>	Vision Test		<input type="checkbox"/>	<input type="checkbox"/>	
Height	_____ inches		<input type="checkbox"/>	<input type="checkbox"/>	Hearing Test		<input type="checkbox"/>	<input type="checkbox"/>	
Weight	_____ lbs. _____ oz.		<input type="checkbox"/>	<input type="checkbox"/>	Lead	_____			
Other:			<input type="checkbox"/>	<input type="checkbox"/>	HGB/HCT	_____			
Section 4-Overall Results									
			Normal	Abnormal			Yes	No	
Overall Impression of Health			<input type="checkbox"/>	<input type="checkbox"/>	Follow-up or Referral Needed		<input type="checkbox"/>	<input type="checkbox"/>	
Comments:									

Health Professional Signature: _____ Date: _____