

STANDARD CHILD MEDICAL HEALTH TESTING RESULTS

Child Name: _____

Unit Name: _____

Measurements

Date	Height	Weight	Head Circ	Funding	Comments/Initials
/ /	[] [] ~ [] [] / 8	[] [] ~ [] [] OZ	[] [] ~ [] [] / 8	<input type="checkbox"/> Partially by HS <input type="checkbox"/> Fully by HS <input type="checkbox"/> EPSDT/Medicaid <input type="checkbox"/> Other Agency	
/ /	[] [] ~ [] [] / 8	[] [] ~ [] [] OZ	[] [] ~ [] [] / 8	<input type="checkbox"/> Partially by HS <input type="checkbox"/> Fully by HS <input type="checkbox"/> EPSDT/Medicaid <input type="checkbox"/> Other Agency	

Hearing

Date		Results	Funding	Comments/Initials
		5 0 0 1 0 0 0 2 0 0 0 4 0 0 0		
/ /	Right	[] []	<input type="checkbox"/> Partially by HS <input type="checkbox"/> Fully by HS <input type="checkbox"/> EPSDT/Medicaid <input type="checkbox"/> Other Agency	
	Left	[] []		

Needs Treatment

Vision

Date	Left	Right	Both	Funding	Comments/Initials
/ /	20/ [] []	20/ [] []	20/ [] []	<input type="checkbox"/> Partially by HS <input type="checkbox"/> Fully by HS <input type="checkbox"/> EPSDT/Medicaid <input type="checkbox"/> Other Agency	
Strabismus <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal					

Needs Treatment

Lead

Date	Result	Funding	Comments/Initials
/ /	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> Refused <input type="checkbox"/> Rescreen	<input type="checkbox"/> Partially by HS <input type="checkbox"/> Fully by HS <input type="checkbox"/> EPSDT/Medicaid <input type="checkbox"/> Other Agency	

Needs Treatment