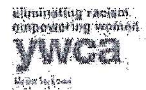
YWCA ST. LOUIS EARLY EDUCATION PROGRAM



Well Baby Visit Form

Name ______________________________ Date of Birth ______________

AGE IN MONTHS									
☐ Newborn to 1 Month	☐ 2	☐ 4	☐ 6	☐ 9	☐ 12	☐ 15	☐ 18	☐ 24	☐ 36

Weight	Height	BP (3 years and older)

SYSTEM	NORMAL	ABNORMAL	FOLLOW UP/COMMENTS
PHYSICAL			
EENT			
CARDIAC			
RESPIRATORY			
ABDOMINAL			
GENITO-URINARY			
NEUROLOGICAL			
DENTAL SCREEN			
SKIN			
HEARING			
VISION			

LEAD (12 or 24 Months) Date __________ Result __________ Doctor Refused ☐

HEMOGLOBIN (12 Months) Date __________ Result __________ Doctor Refused ☐

DENTAL SCREEN			

Did the child receive an application of fluoride varnish? ☐ Yes ☐ No

ALLERGIES:

MEDICATIONS:

NEXT VISIT:

IMMUNIZATIONS ADMINISTERED

DTAP#	IPV#	HIB#	MMR#	HEP#	PCV#	VARICELLA#	OTHER

NEXT IMMUNIZATION DUE:

Was a Dyslipidemia Assessment performed? ☐ Yes ☐ No Comment: ______________________

Was the child referred for further evaluation? ☐ Yes ☐ No If yes, please explain: ______________________

Does the child require any specialized care? ☐ Yes ☐ No If yes, please explain: ______________________

I have examined the above-named child and verify that this child's medical history and current state of health ☐ are ☐ are not satisfactory for participation in the YWCA St. Louis Early Education Program.

Physician's Name (please print) ______________________ **Telephone** ______________

Physician's Signature ______________________ **Date of Exam** ______________

HN Unit 9/19
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