STANDARD CHILD MEDICAL HEALTH TESTING RESULTS

Child Name: _____

Unit Name: _____

Measurements

Date	Height	Weight	Head Circ	Funding	Comments/Initials
/ /	___~ ___/8	___~ ___OZ	___~ ___/8	☐ Partially by HS ☐ Fully by HS ☐ EPSDT/Medicaid ☐ Other Agency	
/ /	___~ ___/8	___~ ___OZ	___~ ___/8	☐ Partially by HS ☐ Fully by HS ☐ EPSDT/Medicaid ☐ Other Agency	

Hearing

Date		Results				Funding	Comments/Initials
		5 0 0	1 0 0 0	2 0 0 0	4 0 0 0		
/ /	Right	___	___	___	___	☐ Partially by HS ☐ Fully by HS ☐ EPSDT/Medicaid ☐ Other Agency	
	Left	___	___	___	___		

☐ **Needs Treatment**

Vision

Date	Left	Right	Both	Funding	Comments/Initials
/ /	20/ ___	20/ ___	20/ ___	☐ Partially by HS ☐ Fully by HS ☐ EPSDT/Medicaid ☐ Other Agency	
Strabismus	☐ Normal	☐ Abnormal			

☐ **Needs Treatment**

Lead

Date	Result	Funding	Comments/Initials
/ /	☐ Normal ☐ Abnormal ☐ Refused ☐ Rescreen _____ Results	☐ Partially by HS ☐ Fully by HS ☐ EPSDT/Medicaid ☐ Other Agency	

☐ **Needs Treatment**