Community **Action** Partnership of Ramsey & Washington Counties

Child & Teen Check-Up Exam

Name _____ **DOB:**____/____/____ **Gender**: ☐ M ☐ F

Is child up to date with C&TC including all required tests: ☐Yes☐No If no, what is not complete: _____
Are Immunization up-to-date (*Please attach a copy*): ☐ Yes ☐ No

Height:_____in. Weight:_____lbs. ☐ No Concern ☐ Concern

Blood Pressure:_____/_____☐ No Concern ☐ Concern

Vision Status: ☐No Concern ☐Concern ☐Unable ☐Refer
R 20/_____ L 20/_____ Corrected:☐ Yes ☐ No
Photo Screener: ☐ Pass ☐ Refer
Hearing Status: ☐No Concern ☐Concern ☐Unable ☐Refer

	500 (25)	1000 (20)	2000 (20)	4000 (20)
Right				
Left				

**Required by HS-Previous dates acceptable*

*Lab	Date	Results	Comments
*Hemoglobin			
*Blood Lead Level			

Area	N	AB	Comments	Area	N	AB	Comments
General Appearance				Lungs			
Head				Abdomen			
Face				Genitourinary			
Eyes				Musculoskeletal			
Ears				Spine			
Mouth-Teeth				Extremities			
Throat				Skin			
Nose				Neurological			
Neck				Nutritional Status			
Cardiovascular				Emotional Status			
Chest				Speech			

Allergies: _____
Routine Medications: _____
Is child developing appropriately for his/her age? ☐ No ☐ Yes, please specify: _____
Is a special diet necessary? ☐ No ☐ Yes, please identify restrictions: _____
Is there a condition which may result in an emergency? ☐ No ☐ Yes, please specify: _____
Is there a condition that may interfere with learning? ☐ No ☐ Yes, please specify: _____
Please indicate any present health conditions: _____

Any restrictions or recommendations: _____

***Well Baby Exam Date:**_____	1 mo.	2 mo.	4 mo.	6 mo.	9 mo.	12 mo.	15 mo.	18 mo.	24 mo.	30 mo.
	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Signature of Health Care Provider: _____ **Date Signed:** _____
Print Providers Name: _____
Clinic Name: _____
Address_____ Phone: _____ Fax: _____