Washington State Department of CHILDREN, YOUTH & FAMILIES

Snohomish County

Snohomish County ECEAP

Form: WELL CHILD CHECK

Child: _____ Birthdate ____/____/____

PLEASE DO NOT SEND A COPY OF CHILD'S MEDICAL RECORD. COMPLETE THIS FORM ONLY.

Date of exam:	Height:	Weight:	BMI:	Hearing: Vision:
Comprehensive EPSDT exam completed (please circle one): 3 year 4 year 5 year			Next exam due:	
Immunizations given this visit: (Please attach CIS or COE form)				
Fluoride prescribed? (Circle) YES NO	Anemia screening completed? _____ Yes _____ Not recommended		Lead screening completed? _____ Yes _____ Not recommended	

YES	NO	HEALTH STATUS
		Are you serving as this child's primary health care provider?
		Is this child up to date on an age-appropriate schedule of preventative and primary health care?
		Are immunizations up to date for this child?
		Is this child diagnosed as needing medical treatment for any of the following: (If yes, please note any recommendations or restrictions in comments section below.)
		Does this child have any severe allergies or chronic health conditions?
		Are there any life-sustaining medications prescribed for this child?
		Vision or hearing concerns?
		Developmental or growth concerns?
		Nutrition concerns?
		Dental concerns?
		Was child treated for any of the above listed conditions?

Provider comments:

Provider signature:	Date:

Contact Information
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