MIAMI-DADE COUNTY
COMMUNITY ACTION AND HUMAN SERVICES DEPARTMENT
HEAD START/EARLY HEAD START DIVISION

MEDICAL SCREENING FORM

CENTER NAME: ______________________ CLASS ROOM: ____________

CHILD'S NAME: ______________________ DATE OF BIRTH: ____________

PARENT/GUARDIAN NAME: ______________________

HEMOGLOBIN / HEMATOCRIT

DATE	AGE	RESULTS	
		Hgb (#)	Hcto (%)

LEAD SCREENING

DATE	AGE	TEST RESULTS In micrograms per deciliter ONLY (mcg/DL)

BLOOD PRESSURE READING (3-5 YEAR OLD)

DATE	AGE	RESULTS

HEAD CIRCUMFERENCE (EARLY HEAD START ONLY 0-36 MONTHS)

DATE	AGE	RESULTS (In Centimeters CM)

I confirm that I have completed the services indicated above.

AGENCY STAMP HERE: ______________________

______________________ ____________
Medical Provider/Agency Signature Date